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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O2VH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00624

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245446**

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

3. NAME AND ADDRESS OF FACILITY
(L3) **ASSUMPTION HOME**
(L4) **715 NORTH FIRST STREET**
(L5) **COLD SPRING, MN** (L6) **56320**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/31/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	82			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Brenda Fischer, Unit Supervisor 01/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 01/07/2019 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **03/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **12/11/2018** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
January 7, 2019

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

RE: Project Number S5446030

Dear Administrator:

On November 28, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 16, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 31, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 7, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2019. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 16, 2018, effective January 4, 2019 and therefore remedies outlined in our letter to you dated November 28, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
CMS Certification Number (CCN): 245446

January 7, 2019

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 4, 2019 the above facility is certified for:

82 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 82 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O2VH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00624

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(L1) **245446**

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

3. NAME AND ADDRESS OF FACILITY
(L3) **ASSUMPTION HOME**
(L4) **715 NORTH FIRST STREET**
(L5) **COLD SPRING, MN** (L6) **56320**

4. TYPE OF ACTION: **2** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/16/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	82			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE
Timothy Rhonemus, HFE NE II
Date: 12/06/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL
Alison Helm, Enforcement Specialist
Date: 12/07/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

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21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

Electronically delivered
November 28, 2018

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

RE: Project Number S5446030

Dear Administrator:

On November 16, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is December 26, 2018.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by February 16, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 16, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 ______	11/16/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/13/18 through 11/16/18 at Assumption Home, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/13/2018 through 11/26/2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 697		12/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/04/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	11/16/2018

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 697	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct a comprehensive pain assessment for 1 of 1 residents (R33) in the sample whom complained of pain and discomfort with movement. Finding include: R33's quarterly Minimum Data Set (MDS) dated 9/21/18 identified R33 was cognitively intact, no behaviors and needed extensive assistance with bed mobility, transfers, and only completed ambulation one or two times during the assessment period. The MDS also indicated R33 had frequent episodes of pain, rating it a 6 on a 0-10 pain scale, of 10 being the worst pain and zero no pain. R33 was on scheduled and as needed pain medications. R33 was interviewed on 11/13/18 at 2:29 p.m. stated she had left hip and bilateral knee pain. The pain resulted from arthritis (inflammation in the joints) and she was on scheduled pain medications which did not eliminate the pain, and only took the edge off. She continued to state she was not a candidate for any surgery because of her health condition. During observation on 11/13/18 05:18 p.m. R33 complained of pain in her knees, and left leg identifying the mornings were the worst time for pain. She is stiffer in the morning has more pain, and feels rushed by staff when they assist her. The rest of the day goes better, but the early morning were the hardest. R33 lifted her legs up approximately 4 inches off the seat of the	F 697	It is the policy of Assumption Home to gather all data available to address one's level of discomfort or pain. It is also the policy of Assumption Home that all residents will be assessed for pain upon admission, readmission, quarterly, annually, with significant change in status as defined by the Minimum Data Set, and with change in status of pain from resident baseline. The Director of nursing will designate Registered Nurses to review all residents for risk and potential for actual pain to ensure all residents will have a person centered approach to their pain management that is satisfying in meeting their pain management needs. The review will encompass current pain strategies as well as potential for implementation or changing of the regimen. IDT will monitor and review all pain notes daily as well as PRN administration level notes to ensure effectiveness is being reached. Daily IDT forms will be updated to reflect this. The Director of Nursing will conduct random audits ensure appropriate person centered interventions are in place in order to reach a satisfying pain management regimen. Audit results will be presented to the next Quality Assurance/Performance Improvement Committee meeting. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	11/16/2018

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 697	Continued From page 2 wheelchair, and had facial grimacing and wincing while doing this. She stated this was hard to do, because of the knee pain. R33's pain management Care Area Assessment (CAA) on 9/21/18 identified R33 has chronic pain, with hip pain that comes and goes every few months. Has scheduled and as needed pain medications along with rest, heat. The assessment also identified cortisone injections (medication to treat inflammation) had been discontinued as of 9/21/18 per resident request. The assessment did not identify any time frames when R33's pain was better or worse to determine appropriate medication time frames, to help alleviate R33's pain and discomfort. R33's care plan updated 10/5/2018 identified an alteration in pain to left hip, gout and osteoarthritis. Staff were directed to provide warm packs, pain medications, listen to resident concerns, identify pain, location and intensity using 0-10 scale. The care plan also directed staff to acknowledge presence of pain and discomfort, listen to resident concerns. R33's physician orders as of 11/15/18 identified Tylenol 1000 mg (pain medication) three times a day and as needed for breakthrough pain which started on 4/12/18; oxycodone 5 mg (narcotic pain medication) every 2 hours as needed started on 4/12/18, and morphine Sulfate ER extended release (narcotic pain medication) 15 mg (milligrams) twice a day which was started on 9/7/18.	F 697	committee will review and make necessary recommendations based on the findings. Facility will be in compliance by December 26th, 2018.	

F 697 | F 697

Continued From page 3

Review of the medication administration record from September to November 2018, identified a pain scale response of 0-10, identified the following:
September average pain scale rating at 8:00 a.m. was 4.24 and 8:00 p.m. was 3.1
October average pain scale rating at 8:00 a.m. was 6.2, and 8:00 p.m. was 2.4
November 1-15, 2018 average pain scale rating at 8:00 a.m. was 5.0, and 8:00 p.m. was 4.1.

During interview on 11/14/18 at 2:38 p.m. nursing assistant (NA)-A stated she works with R33 and assists her when she transfers and walks. When we transfer her she does complain of pain in her knees and legs, she grimaces and asked for pain medications, mornings seem to be harder for her.

On 11/14/18 03:07 p.m. licensed practical nurse (LPN)-A stated she noticed R33 has had more difficulty with pain in the morning with the NA's physically helping her more and in the evenings she is independent. R33 gets up early between 5:00-7:00 a.m. and they give her Tylenol and morphine which seems to help. Review of the record with LPN-A identified the morphine was given at 8:00 a.m. and 8:00 p.m. and Tylenol was given at 6:00 a.m., 12:00 p.m. and 8:00 p.m. LPN-A stated they should be giving the morphine at 6:00 a.m. with the Tylenol to help alleviate her pain since she gets up early and has more problems in the morning.

During interview on 11/14/18 at 3:00 p.m. registered nurse (RN)-A stated they monitor R33's pain twice a day which is routine for any resident who received pain medications. Review of the October and November MAR with RN-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING ______ B. WING ______	11/16/2018

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

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F 697	Continued From page 4 identified R33 rated her pain, on a 0-10 pain scale, as 4-6 in the morning, and 2-3 in the afternoon for the past month. She agreed changing the 8:00 a.m. morphine to 6:00 a.m. may be more beneficial since R33 seems to have more pain in the early morning hours when she is getting ready for the day. The facility policy entitled Pain Scale and Intervention, updated October 2018, identified pain assessments are completed as needed, annually and quarterly along with collecting data from residents using a pain scale rating of 0-10 scale. Based upon the collection of data, the nurse will treat pain with non-pharmacological and pharmacological interventions and document accordingly.	F 697		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		12/26/18

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F 880	Continued From page 5 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 6 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to removed soiled gloves after administering a blood glucose testing using a glucometer for 1 of 1 residents (R8) observed having a glucometer test completed. Findings include: R8 was observed on 11/13/18 at 5:44 p.m. receiving her blood glucose level from licensed practical nurse (LPN)-B. LPN-B has gloves on , and obtained a blood sample from R8's finger placing the blood on the testing strip that was inserted into the glucometer. Once LPN-B obtained the blood sample and reading she removed the test strip, placed the glucometer in a plastic bag and left R8's room without first removing her soiled gloves. LPN-B returned to the medication cart, and opened a drawer and placed the testing strip container and glucometer in two separate compartments with her soiled gloves. She closed the medication drawer, and then removed her soiled gloves and washed her hands. Immediately after the procedure, LPN-B stated, she should have removed her soiled gloves after finishing the glucose reading and before leaving the residents room. She has been a nurse a long time, and still gets nervous.	F 880	It is the policy of Assumption Home to perform hand hygiene before and after contact with each resident. It is mandatory that direct caregivers wear gloves when doing resident care that may involve contact with any body fluid. It is also mandatory that gloves are removed prior to moving onto a clean task and hands are washed as to not contaminate clean surface and articles. Director of Nursing will facilitate a Hand Hygiene and Glove Use policy review along with a competency quiz with all Nursing staff who perform Blood Glucometer checks, (LPNs, RNs and TMAs). During the review the portion regarding glove removal/hand hygiene before moving onto a clean task will be emphasized. Following review of policy, weekly audits of glucometer usage/hand hygiene related to this will be completed by the RN Leadership team times 4 weeks. If deficient practice is still noted during audits, further 1:1 education will be provided. Audit results will be presented to the next Quality Assurance/Performance Improvement Committee meeting. The	

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F 880	Continued From page 7 The facility policy entitled, Glove Usage, revised 9/17 identified, gloves should be worn for one procedure and one resident only. After carrying out the procedure, remove the contaminated gloves, and place gloves in clinical waste container and wash hands.	F 880	committee will review and make necessary recommendations based on the findings. Facility will be in compliance by December 26, 2018.	

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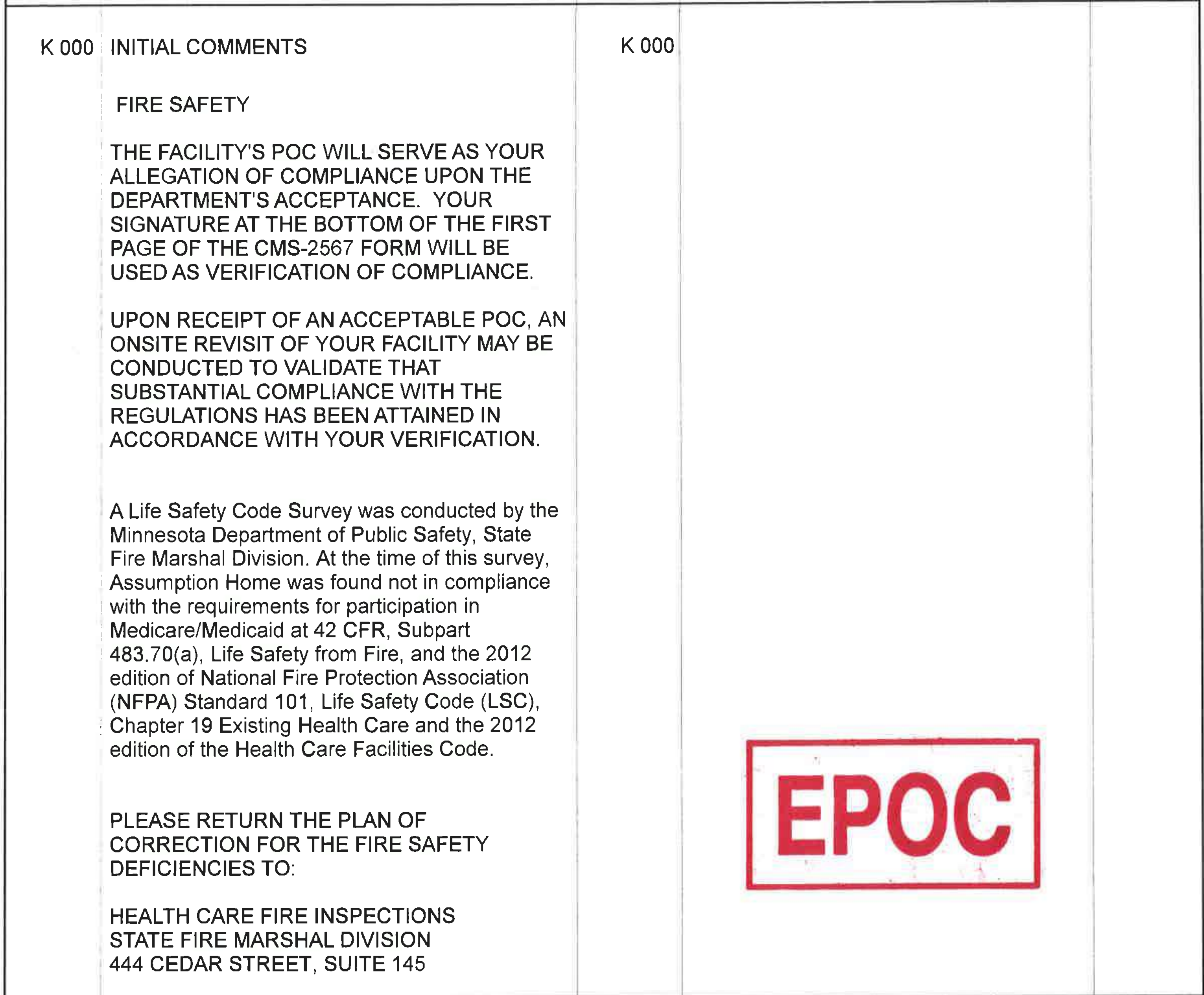

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Assumption Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/06/2018

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

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K 000 | Continued From page 1 | K 000

ST. PAUL, MN 55101-5145, or

By e-mail to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Assumption Home is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1988, an addition was added to the west of the original basement and was determined to be of Type II (000). In 1996 a kitchen addition was added to the north east end of the 1963 building and was determined to be of Type II (000) construction. The 1963 building is separated, by a 2-hour fire barrier, from an attached apartment building to the north and the 1963 building is separated by a 2-hour fire barrier from an attached connecting link to an apartment building to the east. In 2009 two wings were constructed to the North of the 1988 addition. The south west wing is a 1 story and a basement and the North wing is a two story and was determined to be of typed II (000) construction. In 2010 a 1 story with no basement addition was added to the south side of the facility

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K 000	Continued From page 2 and was determined to be a type II (111) construction. The facility is protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are centrally monitored. There is smoke detection in the resident sleeping rooms that is supervised by the nurse call system. The facility has a licensed capacity of 82 beds and had a census of 73 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		12/3/18

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K 321	Continued From page 3 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to construct 1 hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 1:30 pm on 11/14/2018 observations revealed the Heritage housekeeping storage room was over 50 sq ft and did not have a self-closing door. This deficient condition was confirmed by the Director of Environmental Services.	K 321	A door closure was added to the Heritage housekeeping storage room door on 12-03-18. This closure was installed and tested by Mid Central Door to verify proper latching upon self-closure. Responsible Person = Erik Burr – Director of Environmental Services	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the	K 341		12/31/18

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K 341	Continued From page 4 building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This **REQUIREMENT** is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of residents. Findings include: On the facility tour between 9:30 am to 1:30 pm on 11/14/2018 observations revealed: 1. The lower level construction storage room did not have a smoke detector on both sides of the 16 inch header. 2. The smoke detector in the Garden view dining room was within 36 inches of an HVAC diffuser. This deficient condition was confirmed by the Director of Environmental Services.	K 341	1.With the assistance of Summit Companies, it was determined via on-site review that they will be installing two new smoke detectors to the lower level construction storage room. With one smoke detector already in place on the south side of the 16 inch header, the two new smoke detectors will be added to the north side of the 16 inch header which encompasses a majority of the space within the storage room. These two new smoke detectors will be installed and tested prior to 12-31-18 and will be an addition to our current fire alarm system. Responsible Person = Erik Burr – Director of Environmental Services 2.The smoke detector in the Gardenview dining room that was within 36 inches of the HVAC supply air diffuser was relocated by Hi-Tec Electric on 11-27-18. The smoke detector is now 52" from the nearest HVAC diffuser.	

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K 341	Continued From page 5	K 341	Responsible Person = Erik Burr – Director of Environmental Services	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to install sprinkler heads in accordance with the 2012 edition of the Life Safety Code (NFPA 101) sections 19.3.5.1, 9.7.1.1 and the 2010 edition of NFPA 13, The Standard for the Installation of Sprinkler Systems. This deficient practice could cause a delay in extinguishing a fire affecting the safety of an undetermined amount of residents. Findings include:	K 351	Johnson Controls/Simplex Grinnell will be installing a new sprinkler head and associated sprinkler piping under the overhead door track in the heated garage on 12-13-18. Responsible Person = Erik Burr – Director of Environmental Services	12/13/18

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K 351	Continued From page 6 On the facility tour between 9:30 am to 1:30 pm on 11/14/2018 observations revealed there was no sprinkler head installed under the overhead door track in the heated garage. This deficient condition was confirmed by the Director of Environmental Services.	K 351		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _______________ b) Who provided system test _______________ c) Water system supply source _______________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the	K 353	1.Johnson Controls/Simplex Grinnell assisted the Director of Environmental Services in identifying all painted sprinkler heads in the 1963 basement storage room #1, the AmeriPride storage room, and in the laundry room. Based on this	12/17/18

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K 353	Continued From page 7 sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 82 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 1:30 pm on 11/14/2018 observations revealed; 1. Painted sprinkler heads in the 1963 basement storage room #1, in the Ameri Pride storage room an in the laundry room. 2. A ceiling tile in clean utility room H1 had a 2 1/2 inch hole in it. 3. A light in the kitchen storage room blocked a sprinkler head. This deficient condition was confirmed by the Director of Environmental Services.	K 353	review, it was determined that approximately 90% of the total sprinkler heads in these areas were affected and needed to be replaced. As a result, we decided to replace all sprinkler heads in the affected areas to be consistent and uniform. The sprinklers will be replaced on 12-13-18 through 12-17-18. Responsible Person = Erik Burr – Director of Environmental Services 2.The ceiling tile in the clean utility room H1 that had a 2 ½" hole in it was repaired on 11-21-18 by Erik Burr. Responsible Person = Erik Burr – Director of Environmental Services 3.The light in the kitchen storage room that was blocking a sprinkler head was removed on 11-27-18 by Hi-Tec Electric. The blocking surface-mounted light fixture was removed and a flat panel LED fixture was installed to be flush with the ceiling grid and is no longer blocking the sprinkler head. Responsible Person = Erik Burr – Director of Environmental Services	
K 364 SS=D	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut.	K 364		1/4/19

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K 364	Continued From page 8 In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to control the openings in a corridor wall in accordance with the 2012 of the Life Safety Code (NFPA 101) section 19.3.6.4.1. This deficient practice could allow for smoke to enter the corridor and make in untenable, affecting the exiting of all staff and visitors in the lower level. Findings include: On the facility tour between 9:30 am to 1:30 pm on 11/14/2018 observations revealed a transfer grille in the corridor wall from the activity storage room in the 2009 addition. This deficient condition was confirmed by the Director of Environmental Services.	K 364	With the assistance of Climate Makers Inc., Hi-Tec Electric, and Summit Companies, a solution was found to eliminate the transfer grille in the corridor wall from the activity storage room in the 2009 addition. The following work will be completed by 01-04-19: •Removal of the transfer grille and sheetrock repair by Assumption staff. •Installation of return-air ductwork and fire/smoke damper by Climate Makers Inc. •Electrical installation for the fire/smoke damper and tie-in to the fire alarm system by Hi-Tec Electric and Summit Companies. •Testing of the fire alarm system to ensure correct operation of the fire/smoke damper with the fire alarm system by Summit Companies. •Visual confirmation of the fire/smoke damper operation by Climate Makers Inc. •Addition of the fire/smoke damper to the Assumption facility testing log by Erik Burr	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245446	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/14/2018**

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

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K 364	Continued From page 9	K 364	Responsible Person = Erik Burr – Director of Environmental Services	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2..4.2.1 and the use of power strips comply with 10.2.4. This deficient practice could affect and an undetermined amount of	K 920	The 3-plug adapter in use in resident room H-2 and the extension cord in use in resident room C-8 were removed on 11-15-18. Assumption staff will complete and document a full facility review in search of any unapproved electrical cords	1/4/19

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	245446	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/14/2018**

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K 920	Continued From page 10 residents, staff and visitors. Findings include: On the facility tour between 9:30 am to 1:30 pm on 11/14/2018 observations revealed a 3 plug adapter in use in resident room H-2 and an extension cord in use in resident room C-8. This deficient condition was confirmed by the Director of Environmental Services.	K 920	and adapters and remove any found by 01-04-19. In addition to our currently in place annual receptacle test and inspection, Assumption will be specifically educating housekeeping staff by 01-04-19 to look for unapproved electrical extension cords and adapters during their daily interaction with every resident room, and report any findings to the Director of Environmental Services. A review will be done by 01-04-19 of our Admission policy to ensure the residents and responsible parties (family) are being communicated to upon admission of the facility policy forbidding extension cords and electrical adapters. All staff will also be educated via an all campus email by 01-04-19 and instructed to continually look for and report any extension cords or electrical adapters in resident rooms. The facility policy regarding extension cords and electrical adapters will also become an agenda item to communicate at the quarterly Family Council meetings. Responsible Person = Erik Burr – Director of Environmental Services	

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
November 28, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5446030

Dear Administrator:

The above facility was surveyed on November 13, 2018 through November 16, 2018 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

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

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

Please feel free to call me with any questions.

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00624	A. BUILDING: ____ B. WING ____	11/16/2018

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

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 12/04/18

Minnesota Department of Health

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 11/13/18 through 11/16/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	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 observation, interview and document review the facility failed to conduct a comprehensive pain assessment for 1 of 1 residents (R33) in the sample whom complained of pain and discomfort with movement. Finding include: R33's quarterly Minimum Data Set (MDS) dated 9/21/18 identified R33 was cognitively intact, no behaviors and needed extensive assistance with bed mobility, transfers, and only completed ambulation one or two times during the assessment period. The MDS also indicated R33	2 830	Corrected	12/26/18

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2 830	Continued From page 3	2 830		

had frequent episodes of pain, rating it a 6 on a 0-10 pain scale, of 10 being the worst pain and zero no pain. R33 was on scheduled and as needed pain medications.

R33 was interviewed on 11/13/18 at 2:29 p.m. stated she had left hip and bilateral knee pain. The pain resulted from arthritis (inflammation in the joints) and she was on scheduled pain medications which did not eliminate the pain, and only took the edge off. She continued to state she was not a candidate for any surgery because of her health condition.

During observation on 11/13/18 05:18 p.m. R33 complained of pain in her knees, and left leg identifying the mornings were the worst time for pain. She is stiffer in the morning has more pain, and feels rushed by staff when they assist her. The rest of the day goes better, but the early morning were the hardest. R33 lifted her legs up approximately 4 inches off the seat of the wheelchair, and had facial grimacing and wincing while doing this. She stated this was hard to do, because of the knee pain.

R33's pain management Care Area Assessment (CAA) on 9/21/18 identified R33 has chronic pain, with hip pain that comes and goes every few months. Has scheduled and as needed pain medications along with rest, heat. The assessment also identified cortisone injections (medication to treat inflammation) had been discontinued as of 9/21/18 per resident request. The assessment did not identify any time frames when R33's pain was better or worse to determine appropriate medication time frames, to help alleviate R33's pain and discomfort.

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2 830	Continued From page 4	2 830		

R33's care plan updated 10/5/2018 identified an alteration in pain to left hip, gout and osteoarthritis. Staff were directed to provide warm packs, pain medications, listen to resident concerns, identify pain, location and intensity using 0-10 scale. The care plan also directed staff to acknowledge presence of pain and discomfort, listen to resident concerns.

R33's physician orders as of 11/15/18 identified Tylenol 1000 mg (pain medication) three times a day and as needed for breakthrough pain which started on 4/12/18; oxycodone 5 mg (narcotic pain medication) every 2 hours as needed started on 4/12/18, and morphine Sulfate ER extended release (narcotic pain medication) 15 mg (milligrams) twice a day which was started on 9/7/18.

Review of the medication administration record from September to November 2018, identified a pain scale response of 0-10, identified the following:
September average pain scale rating at 8:00 a.m. was 4.24 and 8:00 p.m. was 3.1
October average pain scale rating at 8:00 a.m. was 6.2, and 8:00 p.m. was 2.4
November 1-15, 2018 average pain scale rating at 8:00 a.m. was 5.0, and 8:00 p.m. was 4.1.

During interview on 11/14/18 at 2:38 p.m. nursing assistant (NA)-A stated she works with R33 and assists her when she transfers and walks. When we transfer her she does complain of pain in her knees and legs, she grimaces and asked for pain medications, mornings seem to be harder for her.

Minnesota Department of Health

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2 830	Continued From page 5 On 11/14/18 03:07 p.m. licensed practical nurse (LPN)-A stated she noticed R33 has had more difficulty with pain in the morning with the NA's physically helping her more and in the evenings she is independent. R33 gets up early between 5:00-7:00 a.m. and they give her Tylenol and morphine which seems to help. Review of the record with LPN-A identified the morphine was given at 8:00 a.m. and 8:00 p.m. and Tylenol was given at 6:00 a.m., 12:00 p.m. and 8:00 p.m. LPN-A stated they should be giving the morphine at 6:00 a.m. with the Tylenol to help alleviate her pain since she gets up early and has more problems in the morning. During interview on 11/14/18 at 3:00 p.m. registered nurse (RN)-A stated they monitor R33's pain twice a day which is routine for any resident who received pain medications. Review of the October and November MAR with RN-A identified R33 rated her pain, on a 0-10 pain scale, as 4-6 in the morning, and 2-3 in the afternoon for the past month. She agreed changing the 8:00 a.m. morphine to 6:00 a.m. may be more beneficial since R33 seems to have more pain in the early morning hours when she is getting ready for the day. The facility policy entitled Pain Scale and Intervention, updated October 2018, identified pain assessments are completed as needed, annually and quarterly along with collecting data from residents using a pain scale rating of 0-10 scale. Based upon the collection of data, the nurse will treat pain with non-pharmacological and pharmacological interventions and document accordingly.	2 830		

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2 830	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pain to assure they are receiving the necessary treatment/services to prevent pain. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure management of pain. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of	21390		12/26/18

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21390	Continued From page 7 products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to removed soiled gloves after administering a blood glucose testing using a glucometer for 1 of 1 residents (R8) observed having a glucometer test completed. Findings include: R8 was observed on 11/13/18 at 5:44 p.m. receiving her blood glucose level from licensed practical nurse (LPN)-B. LPN-B has gloves on , and obtained a blood sample from R8's finger placing the blood on the testing strip that was inserted into the glucometer. Once LPN-B obtained the blood sample and reading she removed the test strip, placed the glucometer in a plastic bag and left R8's room without first removing her soiled gloves. LPN-B returned to the medication cart, and opened a drawer and placed the testing strip container and glucometer in two separate compartments with her soiled gloves. She closed the medication drawer, and then removed her soiled gloves and washed her hands. Immediately after the procedure, LPN-B stated, she should have removed her soiled gloves after finishing the glucose reading and before leaving the residents room. She has been a nurse a long time, and still gets nervous.	21390	Corrected	

Minnesota Department of Health

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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
21390	Continued From page 8 The facility policy entitled, Glove Usage, revised 9/17 identified, gloves should be worn for one procedure and one resident only. After carrying out the procedure, remove the contaminated gloves, and place gloves in clinical waste container and wash hands. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review the facility policies in regards to handwashing and gloving after checking individual resident blood sugars with the responsible staff. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		