MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Assumption Home
715 North First Street
Cold Spring, MN 56320
Stearns County

Report #: H5446012

Date: April 18, 2013

Date of Visit: January 30, 2013
Time of Visit: 8:00 a.m. – 4:00 p.m.

By: Carrie Euerle, R.N., Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): It is alleged that neglect occurred when a resident was found deceased with her head caught in the grab bar.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)

☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

A preponderance of evidence indicates that neglect occurred when a resident was not assessed for the need to use a grab bar, and the grab bar was left on the bed after the resident had falls from the bed. The resident's neck became entrapped in the grab bar and the resident died of positional asphyxiation.

Review of the resident's medical record revealed that the resident had a diagnosis of dementia, impaired mobility, weakness and chronic pain. The resident required assist of two staff for transfers and bed mobility. The resident's care plan indicated that the resident was at a high risk for falls and had the following interventions in place: a grab bar on the left side of the bed to aid with transfers and bed mobility, a personal tab alarm when in bed or recliner, and a hi/low bed with the bed to be in the low position when the resident was in bed. The resident had a history of falls out of bed and out of the wheelchair. Two months prior to the resident's death the resident had a fall from bed. The resident was found on the floor with half of the resident's body on the floor and the top half of the residents body pressed up against the grab bar. Following this event, an assessment was not completed to determine if continued use of the grab bar was warranted. No consent form was obtained that discussed the risks and benefits of the use of the grab bar. No new fall interventions were implemented following this fall.

Further review of the resident's medical record revealed that there was no assessment or consent form for the use of a grab bar on the left side of the bed.

At the time of the resident's death, the resident was found on the floor by staff with the resident's head between the left grab bar and the mattress. A staff member indicated that upon discovery of the resident, it appeared the resident's neck was "stuck between the mattress and the grab bar". When staff assessed the resident, they were unable to obtain vital signs and the resident was pronounced dead.

Interviews established that the resident was last checked on by staff approximately forty minutes prior to staff discovery of the resident's death.

The resident's death certificate listed the cause of death as positional asphyxia and neck entrapment between the mattress and bedrail.

A facility Assistive Device policy was reviewed that stated that bed devices will be assessed on the mobility assessment and consents to use an assistive device will include risk versus benefit statement. The consent must

be signed and consents will be updated annually.

The bed the resident used was observed it was a hi/low bed with grab bars attached to both the right and left side of the bed.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility had a policy that revealed that the interdisciplinary team would assess for the use of all assistive devices that would include the risks versus benefits of the device. The risk versus benefits would be included on a consent form signed by the resident or responsible party for the use of the device. There was no evidence of an assessment for the use of the grab bar by the interdisciplinary team and no evidence that the risks versus benefits for the use of the device were addressed. There was no evidence that a consent form was obtained for the use of the grab bar. The resident also had previous falls from the bed two months prior, in which no assessment or consent form for the use of the grab bar was completed by the interdisciplinary team.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records	☒ Care Guide
☐ Medication Administration Records	☐ Treatment Sheets
☒ Facility Incident Reports	☐ Physician Progress Notes
☒ ADL (Activities of Daily Living) Flow Sheets	☐ Laboratory and X-ray Reports
☒ Physician Orders	☐ Social Service Notes

☒ Nurses Notes ☐ Meal Intake Records

☐ Activities Reports ☐ Weight Records

☐ Therapy and/or Ancillary Services Records ☒ Assessments

☐ Skin Assessments ☒ Care Plan Records

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☒ Medical Examiner Records ☒ Death Certificate

☒ Police Report

Additional facility records:

☒ Resident/Family Council Minutes ☐ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☐ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 8

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ○ No ◉ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: Facility report

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ○ No ◉ N/A Specify: Resident deceased

Did you interview additional residents: ○ Yes ◉ No

Total number of resident interviews: _____

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 11

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency personnel ☐ Police Officers ☒ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☒ Use of Equipment	☐ Transfers	☐ Incontinence

☐ Call Light ☐ Other: _____

Was any involved equipment inspected: ◉ Yes ○ No ○ N/A

Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A

Were photographs taken: ◉ Yes ○ No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing

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 03/14/2013

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F 000	INITIAL COMMENTS An abbreviated standard survey was initiated to investigate case H5446012. As a result, the following deficiency is issued.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate use of grab bars for 1 of 3 (R1) residents reviewed with recurrent falls from bed. R1 fell out of bed and became entrapped in the grab bar. In addition the facility failed to complete a comprehensive assessment and obtain physician orders for the use of side rails for 2 of 3 (R2, R3) residents reviewed. Findings include: Observation on 1/30/2013 at 10:00 a.m. of R1's bed revealed that R1 had a hi/low bed and grab bars on the left and right side of the bed. The gap between the mattress and the grab bars measured 3.5 inches on the left side. Both grab bars were affixed to the bed properly, formed a closed U shape and had a 3 inch gap between the space of the bars. When the bars were in the	F 323	A.) How corrective action will be accomplished for those residents found to have been affected by deficient practice. Residents 2 & 3 have had re-assessments, revisions to care plans and follow up actions completed March 27, 2013. B.) How facility will identify other residents having potential to be affected by the same practice. 1.) Admission process regarding mobility devices changed to include assessment of bed mobility and bed mobility devices. April 15, 2013 2.) All residents assessed for appropriateness of mobility devices, and changes made as needed. Care plans updated to reflect changes. March 27, 2013	

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

Mrd Rutherford Adm 4.3.13

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

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F 323	Continued From page 1 upright position the grab bars measured 17 inches in length. R1's medical record was reviewed and noted a fall risk/physical device assessment dated 12/28/2012 indicated that R1 had a history of falls and included a box checked "1/2 side rail or grab bar". A Care Plan Review section of the assessment identified that R1 was to have a grab bar to aid in transfers and ambulation. The assessment failed to identify if the resident was able to to use the grab bar, the location of the grab bar, and if two grab bars were to be in use. An informed choice consent for physical devices document reveals that R1 was to have a right side grab bar for use of mobility when in bed. R1's family was informed of the risks of the device use and signed the consent from on 4/28/2011. Documentation failed to support evidence of an assessment and consent form for the use of the left side grab bar. R1's medical record was reviewed and revealed that R1 had dementia. A brief interview for mental status (BIMS) completed on 12/28/2012 revealed a score of 7, indicating severe cognitive impairment. R1's care plan dated 1/8/2013 was reviewed and revealed that R1 was at risk for falls and required the following : a left side grab bar to aid with bed mobility and transfers in and out of bed, assistance of two staff members for bed mobility, personal TAB alarm when in bed or recliner, and a hi/low bed with the bed to be in low position when R1 is in bed. R1's care plan indicated that R1 required the assistance of two	F 323	3.) Walk through facility to verify that the care plan and the mobility devices utilized match. February 4, 2013 C). What measure will be put into place or systematic changes made to ensure that the deficient practice will not occur. 1. Policy and procedures bed mobility assessment updated 1/2013. QA activity found that newly developed assessment did not sufficiently address devices utilized. March 2013 updated policies and procedures updated policies and procedures to reflect actual practice, which also include the definition of right and left side of the bed, and definition of assistive devices and restraints.	

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F 323	Continued From page 2 staff for transfers and assistance of two staff for bed mobility. Review of R1's falls from August 2012-January 2012 revealed that R1 had 5 falls in the last 6 months, 3 falls (11/14/2012, 1/2/2013 and 1/19/2013 were falls out of bed during the night shift. A fall report dated 11/14/2012 at 12:30 a.m. indicated that R1 was found with R1's TAB alarm sounding. The fall report revealed that the lower half of R1's body was on floor mat. The upper half of R1's body was pressed up against the left side rail. A progress note dated 11/15/2012 at 3:47 p.m. indicates that R1's 11/14/2012 fall was reviewed by the interdisciplinary team (IDT). The progress note reveals that the IDT analysis of the R1's fall determined that the fall was caused by the resident attempting to get out of bed due to decreased mobility and that the fall was an isolated incident. New interventions implemented were to monitor the resident and monitor for a pattern of falls. Documentation failed to include evidence that continued monitoring of the resident for a pattern of falls were completed. Documentation lacked to identify that R1's use of the bed grab bar was reassessed. A fall report dated 1/2/2013 at 1:30 a.m. revealed that R1 was found on the floor on the side of R1's bed. R1 was lying supine against the bed frame. The fall report indicated that staff will monitor R1 more frequently to prevent further falls. Documentation failed to include evidence of monitoring of R1 to prevent further falls.	F 323	2.) Updated Mobility Device consent form. April 5, 2013 3.) Revised mobility/fall assessments April 5, 2013 4.) Post follow-up team meetings of on-going staff to assist with the development of fall prevention strategies and assist in the development of ongoing education and orientation programs regarding safety programs. Education provided to staff on new policy and procedures. April, 18, 2013 5.) Updated safety audits. April 12, 2013 6.) Developed Clinical Operations meeting to identify, review and assign clinical issues for follow up within the facility. February 18, 2013	

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F 323	Continued From page 3 A progress note dated 1/2/2013 at 3:49 a.m. revealed that fall prevention interventions initiated at the time of the 1/2/2013 fall were to encourage R1 to use the call light for assistance. A progress noted dated 1/2/2013 at 10:51 a.m. revealed that R1's fall from 1/2/2013 was reviewed and that the IDT determined that the fall was a result of cognitive impairment and weakness. New interventions were to reposition R1 side to side with a pillow every 2-3 hours and as needed when in bed. A fall report dated 1/19/2013 at 6:45 a.m. revealed that R1 ' s TAB alarm was sounding and staff found R1 laying on R1's left side (hip, shoulder and bilateral knees were touching on the floor). The fall report indicated that staff will prevent further falls by providing R1 with a hi/low bed and gripper socks on while in bed. A progress note dated 1/21/2013 at 11:49 a.m. revealed that the IDT reviewed R1's fall from 1/19/2013 and determined R1's fall was related to R1 rolling out of bed. IDT interventions were to change R1 back to a hi/low bed. A progress note dated 1/26/2013 at 1:25 p.m. revealed that at 6:20 a.m. staff found R1 with legs and body out of bed and R1's neck between the mattress and the grab bar of the bed. Staff assessed R1 for signs of life; staff were unable to obtain an apical pulse or a blood pressure. Staff then contacted police, the medical examiner and R1's physician and family regarding the death of R1.	F 323	7.) Revisions have been made to our fall reporting process. Staff educated on updated fall process. April 12, 2013 D.) How facility plans to monitor its performance to make sure that solutions are sustained. 1.) Develop and monitor flow sheet of overall facility fall trends for review and recommendations of the Quality Assurance Committee. April 18, 2013 2.) Audits 10% of residents care plans and actual devices will be completed with care conferencing each week by the Director of Clinical Operations with reports to the Quality Assurance Committee for review and recommendations. April 18, 2013	

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F 323	Continued From page 4 R1's death certificate dated 1/26/2013 was reviewed and revealed that R1's cause of death was positional asphyxiation and neck entrapment between the mattress and bedrail. An interview with RN(A) on 1/30/2013 at 2:25 p.m. revealed that R1 had frequent falls. RN-A also stated that R1 had a hi/low bed when the 11/18/2012 fall occurred but stated that the 1/2/2013 and 1/19/2013 falls occurred from a standard bed. RN-A stated that R1 was given a standard bed in December 2012 because R1 had a period without falls. RN-A stated that R1 was given a hi/low bed following the 1/19/2013 fall. RN-A could not recall the date that the hi/low bed was removed from R1's room or the date that the hi/low bed was placed back in R1's room. An interview with RN-B on 1/30/2013 at 1:40 p.m. revealed that the last mobility assessment that RN-B completed for R1 was completed without witnessing R1 use the grab bar. RN-B stated that staff interviews were used to complete the mobility assessment for R1's use of the grab bar. RN-B also confirmed that R1's care plan included the use of a left side grab bar, however the assessment and consent form indicated that R1 used a right side grab bar. An interview with nursing assistant (NA-A) on 1/30/2013 at 9:40 a.m. revealed that NA-A discovered R1 on the floor on 1/26/2013 when NA-A went in to assist R1 with morning cares. NA-A stated that when NA-A pulled the curtain back in R1's room, R1 was on the floor. NA-A stated that R1 had poor color and R1's neck "looked like it may have been stuck" between the mattress and the grab bar on the bed. R1's bed	F 323		

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F 323	Continued From page 5	F 323		

was in the low position on the floor and R1's body was halfway on the floor with R1's neck resting between the mattress and the grab bar. NA-A stated that R1's TAB alarm had not sounded as it was still clipped to R1's clothing. NA-A then called for the charge nurse to assess R1.

An interview with a licensed practical nurse (LPN-C) on 2/1/2013 at 10:09 a.m. revealed that NA-A alerted LPN-C immediately upon finding R1 on the floor on 1/26/2013. LPN-C stated that R1's body was out of bed with R1's neck between the mattress and the grab bar with R1's face towards the bar. LPN-C indicated that another staff nurse assessed R1 for an apical pulse and blood pressure, which were unable to be obtained. LPN-C indicated that staff then alerted the on-call nurse, the medical examiner, R1's physician, the nursing home administrator, and the police department. LPN-C indicated that once the medical examiner and police "gave the ok" to move R1's body, LPN-C observed that R1 had a bruise across R1's neck. LPN-C described the bruise as "faint blue" and stated that the bruise was across the front of R1's neck under R1's chin.

Observation of R2's bed on 1/30/2013 at 1:00 p.m. revealed that R2 had bilateral ½ side rails.

R2's care plan was reviewed and revealed that R2 had an alteration in mobility and required the assistance of 2 staff and a medi-lift for transfers and bilateral grab bars in bed to aid in bed mobility.

An informed choice consent for physical devices was reviewed and revealed that R2's responsible

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F 323	Continued From page 6 party was educated on the risks of grab bars and signed the consent form on 12/28/2011 for R2 to use grab bars for mobility while in bed. A fall risk/physical device assessment dated 1/3/2013 was reviewed. Under the physical device box, staff had selected the type of physical device used was a ½ side rail or grab bar. The assessment did not reveal which type of physical device was being used by R2. The assessment also revealed that R2 did not have a physician's order for the bilateral ½ side rails that were on R2's bed. Review of R2's physician orders reveals that no order was obtained for the use of ½ side rails. An interview on 1/30/2013 at 1:00 p.m. with RN-A revealed that that R2 had bilateral ½ rails on the bed. R2 confirmed that R2's consent form and care plan indicated that R2 was to have bilateral grab bars. R3 was observed on 1/30/2013 at 1:00 p.m. to have bilateral ½ side rails on R3's bed. R3's care plan dated 12/28/2012 was reviewed and revealed that R3 required the assistance of 2 staff and a Hoyer Lift for bed mobility. R3 required the assistance of one staff member for wheelchair locomotion. An informed choice consent for physical devices was reviewed and revealed that R3 was to be using bilateral grab bars with a trapeze for bed mobility. The consent form indicates that R3's responsible party was informed of the risks of grab bars and provided consent on 3/15/2012.	F 323		

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F 323	Continued From page 7	F 323		

A fall risk/ physical device assessment dated 12/28/2012 revealed that staff selected R3 to be using ½ side rails or grab bar when completing the assessment. The assessment does not indicate which device R3 was using. The assessment also reveals that there was no physician order for the device being utilized by R3.

Review of R3's physician orders revealed that R3 did not have orders for the use of ½ side rails.

An interview on 1/30/2013 at 1:00 p.m. with RN(C) confirmed that R3's bed did have ½ side rails and did not include a trapeze. RN-C also confirmed that the care plan and consent form directed that R3 was to have grab bars and a trapeze to aid in bed mobility.

An interview with RN (B) on 1/30/2013 at 1:40 p.m. revealed that staff complete assessments for grab bars but do not document if the resident is able to use the device. RN-B stated that it is " not documented in the assessment or MDS " if the resident is able to use the grab bar. RN-B stated that " we do it in our heads " when we complete the head to toe assessment on a resident.

A facility policy titled Assistive Device (Bed Mobility) effective January 2013 states that "appropriate use of bed devices will be assessed on the Mobility Assessment". The policy also states that "assistive devices will be care planned under the mobility section of the care plan. The care plan will be reviewed and updated based on assessment" and "consent to use an

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 03/14/2013

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 323	Continued From page 8 assistive device will include risk/benefit statement".	F 323		

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	00624	A. BUILDING: _____ B. WING _____	C 03/14/2013

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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: A complaint investigation was initiated to investigate complaint #H5446012. The following correction order is issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,	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.	

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2 000	Continued From page 1 Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota 55164-0970.	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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	2 830		

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2 830	Continued From page 2 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 ensure appropriate use of grab bars for 1 of 3 (R1) residents reviewed with recurrent falls from bed. R1 fell out of bed and became entrapped in the grab bar. In addition the facility failed to complete a comprehensive assessment and obtain physician orders for the use of side rails for 2 of 3 (R2, R3) residents reviewed. Findings include: Observation on 1/30/2013 at 10:00 a.m. of R1's bed revealed that R1 had a hi/low bed and grab bars on the left and right side of the bed. The gap between the mattress and the grab bars measured 3.5 inches on the left side. Both grab bars were affixed to the bed properly, formed a closed U shape and had a 3 inch gap between the space of the bars. When the bars were in the upright position the grab bars measured 17 inches in length. R1's medical record was reviewed and noted a fall risk/physical device assessment dated 12/28/2012 indicated that R1 had a history of falls and included a box checked "1/2 side rail or grab bar". A Care Plan Review section of the assessment identified that R1 was to have a grab bar to aid in transfers and ambulation. The assessment failed to identify if the resident was able to to use the grab bar, the location of the	2 830		

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2 830	Continued From page 3	2 830		

grab bar, and if two grab bars were to be in use.

An informed choice consent for physical devices document reveals that R1 was to have a right side grab bar for use of mobility when in bed. R1's family was informed of the risks of the device use and signed the consent from on 4/28/2011.

Documentation failed to support evidence of an assessment and consent form for the use of the left side grab bar.

R1's medical record was reviewed and revealed that R1 had dementia. A brief interview for mental status (BIMS) completed on 12/28/2012 revealed a score of 7, indicating severe cognitive impairment. R1's care plan dated 1/8/2013 was reviewed and revealed that R1 was at risk for falls and required the following : a left side grab bar to aid with bed mobility and transfers in and out of bed, assistance of two staff members for bed mobility, personal TAB alarm when in bed or recliner, and a hi/low bed with the bed to be in low position when R1 is in bed. R1's care plan indicated that R1 required the assistance of two staff for transfers and assistance of two staff for bed mobility.

Review of R1's falls in the last from August 2012 through January 2013 revealed that R1 had 5 falls in the last 6 months, 3 falls (11/14/2012, 1/2/2013 and 1/19/2013) were falls out of bed during the night shift.

A fall report dated 11/14/2012 at 12:30 a.m. indicated that R1 was found with R1's TAB alarm sounding. The fall report revealed that the lower half of R1's body was on floor mat. The upper half of R1's body was pressed up against the left side

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2 830	Continued From page 4 rail. A progress note dated 11/15/2012 at 3:47 p.m. indicates that R1's 11/14/2012 fall was reviewed by the interdisciplinary team (IDT). The progress note reveals that the IDT analysis of the R1's fall determined that the fall was caused by the resident attempting to get out of bed due to decreased mobility and that the fall was an isolated incident. New interventions implemented were to monitor the resident and monitor for a pattern of falls. Documentation failed to include evidence that continued monitoring of the resident for a pattern of falls were completed. Documentation lacked to identify that R1's use of the bed grab bar was reassessed. A fall report dated 1/2/2013 at 1:30 a.m. revealed that R1 was found on the floor on the side of R1's bed. R1 was lying supine against the bed frame. The fall report indicated that staff will monitor R1 more frequently to prevent further falls. Documentation failed to include evidence of monitoring of R1 to prevent further falls. A progress note dated 1/2/2013 at 3:49 a.m. revealed that fall prevention interventions initiated at the time of the 1/2/2013 fall were to encourage R1 to use the call light for assistance. A progress noted dated 1/2/2013 at 10:51 a.m. revealed that R1's fall from 1/2/2013 was reviewed and that the IDT determined that the fall was a result of cognitive impairment and weakness. New interventions were to reposition R1 side to side with a pillow every 2-3 hours and as needed when in bed. A fall report dated 1/19/2013 at 6:45 a.m. revealed that R1 ' s TAB alarm was sounding and	2 830		

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2 830	Continued From page 5	2 830		

staff found R1 laying on R1's left side (hip, shoulder and bilateral knees were touching on the floor). The fall report indicated that staff will prevent further falls by providing R1 with a hi/low bed and gripper socks on while in bed.

A progress note dated 1/21/2013 at 11:49 a.m. revealed that the IDT reviewed R1's fall from 1/19/2013 and determined R1's fall was related to R1 rolling out of bed. IDT interventions were to change R1 back to a hi/low bed.

A progress note dated 1/26/2013 at 1:25 p.m. revealed that at 6:20 a.m. staff found R1 with legs and body out of bed and R1's neck between the mattress and the grab bar of the bed. Staff assessed R1 for signs of life; staff were unable to obtain an apical pulse or a blood pressure. Staff then contacted police, the medical examiner and R1's physician and family regarding the death of R1.

R1's death certificate dated 1/26/2013 was reviewed and revealed that R1's cause of death was positional asphyxiation and neck entrapment between the mattress and bedrail.

An interview with RN(A) on 1/30/2013 at 2:25p.m. revealed that R1 had frequent falls. RN-A also stated that R1 had a hi/low bed when the 11/18/2012 fall occurred but stated that the 1/2/2013 and 1/19/2013 falls occurred from a standard bed. RN-A stated that R1 was given a standard bed in December 2012 because R1 had a period without falls. RN-A stated that R1 was given a hi/low bed following the 1/19/2013 fall. RN-A could not recall the date that the hi/low bed was removed from R1's room or the date that the hi/low bed was placed back in R1's room.

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2 830	Continued From page 6 An interview with RN-B on 1/30/2013 at 1:40 p.m. revealed that the last mobility assessment that RN-B completed for R1 was completed without witnessing R1 use the grab bar. RN-B stated that staff interviews were used to complete the mobility assessment for R1's use of the grab bar. RN-B also confirmed that R1's care plan included the use of a left side grab bar, however the assessment and consent form indicated that R1 used a right side grab bar. An interview with nursing assistant (NA-A) on 1/30/2013 at 9:40 a.m. revealed that NA-A discovered R1 on the floor on 1/26/2013 when NA-A went in to assist R1 with morning cares. NA-A stated that when NA-A pulled the curtain back in R1's room, R1 was on the floor. NA-A stated that R1 had poor color and R1's neck "looked like it may have been stuck". R1's bed was in the low position on the floor and R1's body was halfway on the floor with R1's neck resting between the mattress and the grab bar. NA-A stated that R1's TAB alarm had not sounded as it was still clipped to R1's clothing. NA-A then called for the charge nurse to assess R1. An interview with a licensed practical nurse (LPN-C) on 2/1/2013 at 10:09 a.m. revealed that NA-A alerted LPN-C immediately upon finding R1 on the floor on 1/26/2013. LPN-C stated that R1's body was out of bed with R1's neck between the mattress and the grab bar with R1's face towards the bar. LPN-C indicated that another staff nurse assessed R1 for an apical pulse and blood pressure, which were unable to be obtained. LPN-C indicated that staff then alerted the on-call nurse, the medical examiner, R1's physician, the nursing home administrator, and the police department. LPN-C indicated that once the medical examiner and police "gave the ok" to	2 830		

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2 830	Continued From page 7 move R1's body, LPN-C observed that R1 had a bruise across R1's neck. LPN-C described the bruise as "faint blue" and stated that the bruise was across the front of R1's neck under R1's chin. Observation of R2's bed on 1/30/2013 at 1:00 p.m. revealed that R2 had bilateral ½ side rails. R2's care plan was reviewed and revealed that R2 had an alteration in mobility and required the assistance of 2 staff and a medi-lift for transfers and bilateral grab bars in bed to aid in bed mobility. An informed choice consent for physical devices was reviewed and revealed that R2's responsible party was educated on the risks of grab bars and signed the consent form on 12/28/2011 for R2 to use grab bars for mobility while in bed. A fall risk/physical device assessment dated 1/3/2013 was reviewed. Under the physical device box, staff had selected the type of physical device used was a ½ side rail or grab bar. The assessment did not reveal which type of physical device was being used by R2. The assessment also revealed that R2 did not have a physician's order for the bilateral ½ side rails that were on R2's bed. Review of R2's physician orders reveals that no order was obtained for the use of ½ side rails. An interview on 1/30/2013 at 1:00 p.m. with RN-A revealed that that R2 had bilateral ½ rails on the bed. R2 confirmed that R2's consent form and care plan indicated that R2 was to have bilateral grab bars.	2 830		

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2 830	Continued From page 8	2 830		

R3 was observed on 1/30/2013 at 1:00 p.m. to have bilateral ½ side rails on R3's bed.

R3's care plan dated 12/28/2012 was reviewed and revealed that R3 required the assistance of 2 staff and a Hoyer Lift for bed mobility. R3 required the assistance of one staff member for wheelchair locomotion.

An informed choice consent for physical devices was reviewed and revealed that R3 was to be using bilateral grab bars with a trapeze for bed mobility. The consent form indicates that R3's responsible party was informed of the risks of grab bars and provided consent on 3/15/2012.

A fall risk/ physical device assessment dated 12/28/2012 revealed that staff selected R3 to be using ½ side rails or grab bar when completing the assessment. The assessment does not indicate which device R3 was using. The assessment also reveals that there was no physician order for the device being utilized by R3.

Review of R3's physician orders revealed that R3 did not have orders for the use of ½ side rails.

An interview on 1/30/2013 at 1:00 p.m. with RN(C) confirmed that R3's bed did have ½ side rails and did not include a trapeze. RN-C also confirmed that the care plan and consent form directed that R3 was to have grab bars and a trapeze to aid in bed mobility.

An interview with RN (B) on 1/30/2013 at 1:40 p.m. revealed that staff complete assessments for grab bars but do not document if the resident is able to use the device. RN-B stated that it is " not documented in the assessment or MDS " if

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2 830	Continued From page 9	2 830		

the resident is able to use the grab bar. RN-B stated that " we do it in our heads " when we complete the head to toe assessment on a resident.

A facility policy titled Assistive Device (Bed Mobility) effective January 2013 states that "appropriate use of bed devices will be assessed on the Mobility Assessment". The policy also states that "assistive devices will be care planned under the mobility section of the care plan. The care plan will be reviewed and updated based on assessment" and "consent to use an assistive device will include risk/benefit statement".

SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure an environment that is free from accident hazards. The director of nursing or her designee could educate all appropriate staff on these policies and procedures and ensure assessments are completed accurately and thoroughly. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Thirty (30) days

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
Assumption Home
715 North First Street
Cold Spring, MN 56320
Stearns County

Report #: H5446012

Date: May 8, 2013

Date of Visit: May 1, 2013
Time of Visit: 11:00 a.m.

By: Carrie Euerle, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up one federal deficiency and one state licensing order which were issued on March 21, 2013, as the result of an investigation which had been completed on March 14, 2013.

The status of the order is as follow:
1 MN Rule 4658.0520 Subp. 1 - Corrected

See Attached 2567B for status of federal deficiency.

xc: Minnesota Department of Health -Licensing & Certification Division

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245446	A. Building B. Wing	5/1/2013

Name of Facility	Street Address, City, State, Zip Code
ASSUMPTION HOME	715 NORTH FIRST STREET COLD SPRING, MN 56320

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0323 Reg. # 483.25(h) LSC	05/01/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By KL / Cbl	Date: 5/9/13	Signature of Surveyor: 31591	Date: 5/1/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/14/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?		YES NO

AH Form Approved
5/9/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00624	A. Building B. Wing	5/1/2013

Name of Facility	Street Address, City, State, Zip Code
ASSUMPTION HOME	715 NORTH FIRST STREET COLD SPRING, MN 56320

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. LSC	Correction Completed 05/01/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By KL / CBL	Date: 5/9/13	Signature of Surveyor: 31591	Date: 5/1/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/14/2013	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO