DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 25, 2019

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

RE: CCN: 245446
Cycle Start Date: August 9, 2019

Dear Administrator:

On September 18, 2019, the Minnesota Department(s) of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245446	ASSUMPTION HOME

Type of Survey (select all that apply)

A	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 39200			0.25	0.00	0.00	0.00	0.00	0.25
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13.								
14.								

Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 2.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

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

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Team Leader ID 1. 39200			0.25	0.00	0.00	0.00	0.00	0.25
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Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 2.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

Electronically delivered
August 23, 2019

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

RE: Project Number H5446015C and H5446016C

Dear Administrator:

On August 9, 2019, an abbreviated 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is September 18, 2019.

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));

- 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), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
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 November 9, 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 February 9, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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 _____	C 08/09/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/8/19, to 8/9/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5446015C and H5446016C. A deficiency was issued at F744 for H5446015C. An unrelated deficiency was cited at F609. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		9/18/19

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

Electronically Signed | 08/30/2019

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F 609	Continued From page 1 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of verbal abuse were reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for resident to resident abuse. Findings include: The facility resident Protection Program Policy reviewed 7/3/18, defined verbal abuse as the the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to residents or their families. Examples of verbal abuse included, but were not limited to threats of harm; saying things to frighten a resident. Mental abuse included but was not limited to humiliation, harassment and threats of punishment or deprivation.	F 609	It is the policy of Assumption Home to report allegations of verbal abuse to the State Agency in accordance with regulation. A behavior assessment was initiated for R1, and the IDT team conducted a comprehensive care plan review of R1 in consultation with family and physician to identify triggers, implement interventions and prevent further episodes of verbal abuse from occurring between R1 and other residents. Administrator will oversee the reviewing and updating of our Resident Protection Program Policy for clarity and will retrain staff on recognizing, reporting and intervening in instances of verbal abuse.	

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F 609	Continued From page 2 The policy further directed staff to report to the administrator immediately, an incident or suspected incident of abuse. Allegations that involved abuse would be reported to the SA immediately, no later than 2 hours following the incident. R1's quarterly Minimum Data Set dated 7/15/19, identified R1 had severe cognitive impairment and moderate depression symptoms. R1 was identified to have physical and verbal behaviors directed towards others 1-3 times during the assessment period. Diagnoses included dementia and anxiety disorder. R1 was receiving antipsychotic and antidepressant medications. R1's progress note(s) identified the following: 7/7/19, at 8:45 a.m. R1 was shaking her fist and swearing at an unidentified male resident who was seated at R1's table reading a newspaper. 7/10/19, at 8:25 p.m. R1 went into the dining room and a unidentified resident and their spouse were seated at a table. R1 started yelling at the other residents spouse to "get the hell out of there". R1 stated the spouse stunk and wanted her to leave. 7/16/19, at 7:47 p.m. R1 was being verbally rude and aggressive with an unidentified male resident was was seated for a snack at R1's table. R1 stated to the male resident "you stink, you shouldn't be there." R1 then stated "I wish I had a gun, I would just shoot him." The Nursing Home Incident Reporting (NHIR) system did not identify these incidents were reported to the SA as potential verbal abuse.	F 609	IDT will review daily progress notes, staff reports and behavior charting to ensure compliance with policy, and QA/QAPI Committee will audit and review compliance for one year to ensure policy and regulatory compliance. Completion Date: September 18, 2018	

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F 609	Continued From page 3 During interview on 8/9/19, at 8:42 a.m. nursing assistant (NA)-A stated R1 did not share space well with others and was often rude to staff and other residents. She also had been overheard telling others they stunk and felt, R1's verbal behaviors at times was degrading to other. All potential abuse verbal or physical was reported to the floor nurse. During interview on 8/9/19, at 10:38 a.m. licensed practical nurse (LPN)-A stated R1 frequently yelled and swore at other residents. These types of incidents were communicated to the registered nurse (RN) who communicated to the director of nursing (DON) and administrator, and they made a determination if the verbal behaviors were potentially verbal abuse and they made reports to the SA. During interview on 8/9/19, at 11:17 a.m. RN-A stated potential verbal abuse was reported to the administrator and SA if the person on the receiving end of the verbal abuse felt it was abusive or felt threatened. When interviewed on 8/9/19, at 11:59 p.m. the DON and administrator stated they had reread the regulation and the facility policy. The incidents in R1's progress notes on 7/7/19, 7/10/19 and 7/16/19, should have been reported to the SA as potential verbal abuse. They were going to retrain the staff and emphasize the verbal comments themselves are what was reportable versus how someone felt about the verbal comments made.	F 609		
F 744	Treatment/Service for Dementia	F 744		9/18/19

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F 744 SS=D	Continued From page 4 CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess behaviors and implement appropriate interventions to minimize verbal and physical resident to resident altercations for 1 of 3 residents (R1) who was identified to have verbal and physical altercations with staff and residents. Findings include: R1's quarterly Minimum Data Set dated 7/15/19, identified R1 had severe cognitive impairment and moderate depression symptoms. R1 was identified to have physical and verbal behaviors directed towards others 1-3 times during the assessment period. Diagnoses included dementia and anxiety disorder. R1 was receiving antipsychotic and antidepressant medications. R1's Cognitive Loss/ Dementia Care Area Assessment (CAA) dated 4/19/19, identified R1 had an actual problem. Alzheimer's disease and other dementia's were a factor as well as components of delirium, including confusion, disorientation and forgetfulness. R1 had mood and behavioral symptoms. Considerations were identified and included pain. lack of frequent reorientation, reassurance, reminders to help make sense of things, hearing and or vision impairments and interference with residents	F 744	It is the policy of Assumption Home to identify any resident who experiences episodes of altered actions (also commonly known as behaviors) and to ensure said resident is reviewed by the interdisciplinary team (IDT) in order to develop an individualized plan of care that addresses resident□s episodes of altered actions and assist in meeting the psychosocial and comfort needs of resident as well as ensuring resident, and staff safety. Director of Nursing will review and alter the Altered Actions Assessment to ensure assessment facilitates the capturing of specific patterns, triggers ad analysis of the altered actions. Registered Nurses will be designated to review all residents experiencing altered actions and conduct a reassessment and care plan review for these residents to ensure they each have a specific person-centered approach to care planning that captures specific patterns, trends and triggers. IDT will monitor and review all Mood Monitoring Notes daily. The Director of Nursing will conduct random care plan audits to ensure	

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F 744	Continued From page 5 ability to get enough sleep. no input was obtained from R1's family. A care plan would be developed to maintain current level of functioning. The CAA did not identify the residents history and or approaches that were effective. R1's care plan last reviewed on 7/22/19, identified R1 had an alteration in psychosocial well being and an alteration in behaviors as evidenced by negative statements, physical and verbal aggression, ineffective coping related to a cognitive decline/ impairment. Behavioral symptoms were identified as attempting to strike staff, yelling at staff and becoming upset with and yelling at family members. Further, R1's behaviors increased vulnerabilities due to attempts to strike staff and the potential to become aggressive towards other residents. R1 often attempted to assist other residents; however, would then become aggressive when she was unable to assist them. R1 had a history of hitting out at other residents and staff. The following interventions were identified: if resistive reproach later, is often resistive to cares from staff, but will then attempt to complete them independently or demand assistance from staff moments after refusing cares, monitor resident closely in common areas and when interacting with others for aggression and interject as needed, remind resident that if another resident needed assistance to update the staff, R1 was territorial of the dining room and becomes upset when the resident from the other dining rooms visit, discuss feelings about placement with resident, encourage loved ones to visit, discuss feelings of anger/guilt and options of appropriate channeling of these feelings with resident, encourage and praise participation in activities,	F 744	appropriate, specific-person centered interventions are in place. Audit results will be presented at the next Quality Assurance/Performance Improvement Committee meeting. The committee will review and make necessary recommendations based on the findings. Completion Date: September 18, 2019	

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F 744	Continued From page 6	F 744		

explain procedures before beginning them, refer to social worker/pastoral care for evaluation and recommendations, provide emotional support to resident and family as needed, observe and report any changes in mental status and validate feelings and emotions. The care plan did not identify specific triggers and specific interventions for specific behaviors.

R1's psychotropic Medication Monthly Review dated 7/14/19, identified R1 received the following mood altering medications: seroquel (antipsychotic), Ativan (antianxiety)and Celexa (antidepressant). R1 had a diagnosis of dementia with behavioral psychological symptoms and anxiety. R1's target behaviors included verbal and physical aggression, delusional thoughts, refusal of cares and paranoia related to progressing dementia. About half the month so far R1 was resistive to care, mostly in the morning. Resident had an improvement related to cares during the resist of the day. R1 had a few days of hitting out or attempting to hit staff and she had a few days of trying to help other residents. When helping the other residents R1 would become frustrated and angry at times with them. She also continued to have verbal aggression towards staff but at lesser frequency. Non pharmological interventions included redirection and reproach after R1 was left in a safe position, encouraging family to visit, explain all cares prior to completing them and not to re-orientate resident to location and time as she became more upset. No changes to the care plan were made.

R1's Behavior monitoring from 7/14/19, to 8/12/19, identified the following:

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F 744	Continued From page 7	F 744		

- Verbal behaviors including: insulting comments, verbal threats towards staff or others and threatening gestures, no attempt to strike occurred 16 times.

- Physically aggressive behaviors including hitting, threatening gestures, verbal threats occurred 12 times.

- Attempting to assist others and becoming aggressive verbally and or physically with them occurred 27 times.

R1's progress note(s) identified the following:

- 7/7/19, at 8:45 a.m. R1 was shaking her fist and swearing at an unidentified male resident who was seated at R1's table reading a newspaper.

-7/10/19, at 8:25 p.m. R1 went into the dining room and a unidentified resident and their spouse were seated at a table. R1 started yelling at the other residents spouse to "get the hell out of there". R1 stated the spouse stunk and wanted her to leave.

- 7/16/19, at 7:47 p.m. R1 was being verbally rude and aggressive with an unidentified male resident was was seated for a snack at R1's table. R1 stated to the male resident "you stink, you shouldn't be there." R1 then stated "I wish I had a gun, I would just shoot him."

R1's incident reports submitted to the state agency (SA) identified the following:

- 5/12/19, R1 pinched R5 in the arm while trying to get her by her in the wheelchair in the dining room. R1's medications were adjusted. No new

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	245446	A. BUILDING _____ B. WING _____	C 08/09/2019

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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behavioral interventions were identified.

- 6/22/19, R4 stated R1 slapped her in the arm. The incident was not witnessed by any staff. An intervention to increase supervision in common areas was added to R1's care plan; however, what increase in supervision was needed was not identified.

- 8/4/19, staff witnessed R1 slap R4 in the forearm in R1 and R4's room. R4 was moved to a different room as they were roommates. R1's medications were adjusted by the provider. There were no new behavioral interventions addressed for R1.

R1's medical record lacked a comprehensive behavior assessment to address types of behaviors, triggers and person centered specific interventions to limit the behaviors.

During observation on 8/8/19, at 12:53 p.m. R1 pushed herself away from the picnic table after finishing lunch outside. R1 was attempting to take herself back to her room. Nursing assistant (NA) -B approached R1 and asked if she could assist her back to her room. R1 replied "I don't give a shit" NA-A assisted R1 into the building and to her room.

During interview on 8/8/19, at 1:28 p.m. NA-B stated R1 was resistive to cares and was more resistive to cares in the morning versus the afternoon. R1 was very territorial about the dining room and where people sit. She was very rude to staff and other residents and had hit staff and other residents..Residents were not afraid of her but they did not like to be around her. NA-B

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stated she liked hot chocolate and television and those interventions were effective some of the time in redirecting her. She was not instructed on any specific interventions to try for specific behaviors, the staff just try and keep an eye on her. There was not always a warning when R1 became upset but would frequently get an angry face. There was no direction on what to do when R1 was displaying an angry face.

During interview on 8/8/19, at 1:43 p.m. NA-C stated R1 could be very pleasant and was currently on 60 minute checks because she had hit her roommate. R1 became agitated by noise and people chewing loudly. Frequently R1 told people to just shut up.

During interview on 8/8/19, at 1:47 p.m. NA-D stated R1 refused cares and had taken the staff three days just to remove a shirt recently. R1 had bullied R4. If residents or anyone sat in R1's spot in the dining room she became upset. The staff just tell R1 other people can sit there and she just becomes more upset. R1 liked to color, but were not directed to try to get her to color when becoming upset. The staff were not directed to do anything special when R1 had behaviors. The staff just tried to keep an eye on her and intervene when needed.

During interview on 8/8/19, at 1:59 p.m. NA-E stated R1 was very crabby in the morning. She also became upset when anyone was seated in her spot in the dining room. The staff try and separate the other resident from the area. R1's behaviors seemed to be random, without a specific time of day. NA-A was not instructed on what interventions to try for specific behaviors.

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On 8/9/19, from 7:14 a.m. until 7:36 a.m. R1 was seated at the dining room table as other resident came into the dining room for breakfast. R1 was calm. There were no staff directly in the dining room to supervise.

During interview on 8/9/19, at 8:36 a.m. dietary aid (DA)-A stated R1 could be smiling one minute and then next yelling and swearing at people. She was very territorial over the dining room. She swore at other residents all the time. She tried to redirect R1 with hot chocolate but was not given specific instruction on interventions for R1 when she had behaviors in the dining room.

During interview on 8/9/19, at 10:38 a.m. licensed practical nurse (LPN)-A stated R1 had a recent medication change for her behaviors along with visual checks every hour. R1 yelled and swore at other residents and the dining room was where the behaviors occurred the most. The staff just intervene to keep other residents safe.

During interview on 8/9/19, at 11:17 a.m. registered nurse (RN)-A stated the facility had identified pain as potential trigger for behaviors and had made adjustments to her medications. R1 also was very territorial about the dining room. The dining room needed to be supervised when R1 was in there. The interdisciplinary team (IDT) reviewed R1's behaviors, but did not have an assessment to look for patterns in behaviors, such as time, location, staff member. R1's behaviors did not have specific interventions identified for specific behaviors in an attempt to decrease the behaviors other than medication changes. The IDT felt a geriatric hospitalization might help with R1's behaviors but the practitioner felt medication changes in the facility was

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sufficient. R1 had not been referred to in house psychological service to help in behavior triggers and a management plan. RN-A felt R1's behaviors had been comprehensively assessed but was not documented.

When interviewed on 8/9/19, at 11: 59 p.m. the director of nursing (DON) and administrator stated they could make some improvements on on a behavior assessment and interventions for R1. The social worker and chaplain had increased their visits with R1 , but there was no documentation on the visits, including an assessment and additional interventions identified. There was definitely more that could be done to deter R1's behaviors, rather just than identifying causes of the behaviors.

The facility policy Altered Actions dared 3/18, identified residents who were experiencing altered actions/ behaviors were discussed at IDT. When a new behavior or altered action was identified, nursing would initiate a behavior monitoring task. IDT would assess for physical, environmental and comfort issues which could cause behavioral symptoms. Documentation of the IDT assessment, collaboration with the resident/ family, interventions attempted and outcome of attempted interventions would be documented in the assessment.

Electronically Delivered

August 23, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Number H5446015C and H5446016C

Dear Administrator:

A complaint investigation was completed on August 9, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356
Fax: 320-223-7348

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

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

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/8/19, to 8/9/19, surveyors of this Department's staff visited the above provider for a complaint investigation to investigate complaint(s) H5446015C and H5446016C. No correction orders were issued The facility is enrolled in the electronic Plan of	2 000		

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2 000	Continued From page 1 Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		