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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure the appropriate size sling was used and the straps on the EZ Way sling were secured to the mechanical EZ Way smart lift during transfer of 1 of 2 residents (R13) reviewed for mechanical lift transfers. This failure resulted in Immediate Jeopardy to resident health and safety when the loop for the lift sling was not secured properly causing it to come undone. This resulted in R13 sliding out of the sling and falling to the floor. R13 and sustained an abrasion to the posterior head (right side).The Immediate Jeopardy began on 8/3/25 when R13 slid out of the lift sling. The administrator was notified of the immediate jeopardy at 9:02 a.m. on 11/20/25. The immediate jeopardy was removed on 8/12/25, prior to survey and was therefore issued at Past Noncompliance.Findings include:R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 had severely impaired cognition, needed extensive assistance with two people for transfers and R13 had a prognosis that indicated a life expectancy of less than six months, including: progressive supranuclear ophthalmoplegia (progressive damage to brain cells that leads to motor and non-motor symptoms), cerebral atherosclerosis (narrowing arteries in the brain due to buildup of fatty plaques), unspecified dementia with psychotic disturbance, delusional disorder, type II diabetes mellitus (DM) with other circulatory complications, and hypertension (elevated blood pressure). R13's care plan dated 3/21/25, indicated R13 needed a mechanical lift with two staff assistance for transfers. R13's care sheet indicated R13 used a size medium sling. R13's medical record lacked evidence that a sling assessment had been completed. R13's weight on 7/16/25 was 124.8 lbs. EZ Way Smart Lift Operation instructions identified a small sling should be used for resident who weigh 70-100 lbs. Residents who weight 90-220 lbs. should use a medium sling. R13's fall investigation report dated 8/3/25, indicated R13 was being transferred with an EZ Way smart lift from her bed to wheelchair. Staff noted they connected straps on the mechanical lift hooks, crossed the bottom strap between the resident's legs and appropriately attached to lift as well. Staff noted that once R13 was suspended in the air, not over the bed, they noted the strap by R13's left shoulder was not attached to lift. R13 began to slip out of the sling and fell to the floor hitting her head. R13 sustained abrasion to the posterior, right side of head. Report indicated no unsafe practices occurred in the reenactment of transfer. Assistant director of nursing (ADON) determined staff was utilizing a small sling verses a medium sling per care plan. R13's progress note dated 8/3/25 at 2:10 p.m., indicated as needed (PRN) Morphine (a Schedule II controlled substance and opioid analgesic used to treat severe pain) was administered at 11:30 a.m. and was needed for pain due to this event. At 5:48 p.m. it was noted that pain medication had been effective. During interview on 11/19/25 at 10:51 a.m., licensed practical nurse (LPN)-A stated re-training on use of EZ Way lift was provided following R13's fall and included review on paper, hands on practice, and the annual skills fair and competencies. The size of the sling needed was determined by the care coordinator and noted on the electronic and paper care plans. LPN-A stated care staff was trained to ensure correct sling size was being used. LPN-A described the sling was then placed under the resident, and then staff needed to ensure straps were connected correctly and securely. LPN-A stated there were two straps up by residents' shoulders and (continued on next page)

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

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	two by thighs. The same loop was used for both top and bottom straps on the sling. The resident was then raised up over bed or chair, then stopped to ensure straps were not loose. LPN-A stated sling loops had come off before, and sometimes didn't clip all the way, or slid off. During interview on 11/19/25 at 10:52 a.m., NA-C stated, following R13's fall, the facility had a new stop-lift-go program they had been practicing. The program included ensuring the proper lift and sling size were used, followed by ensuring straps were hooked securely and resident was safe to transfer. NA-C stated the resident size was listed on the care plan/care sheet. NA-C stated the manufacturer had people come to the facility to train them on the lifts in September. During interview 11/19/25 at 10:58 a.m., NA- D stated the facility had provided pretty extensive re-training on use of EZ Way lift following R13's fall. NA-D stated training video and in person training had been provided when hired. NA-D stated the residents' specific sling size was found on the care sheet. NA-D described the communication with teammate during the resident transfer while using a mechanical lift. NA-D stated they would raise the resident, then ensured all was safe and secured, before proceeding. During interview on 11/19/25 at 11:01 a.m., NA-E stated the registered nurse (RN) care coordinator assessed the residents and determined the appropriate sling size. NA-E stated the facility provided regular training on the use of the mechanical lifts and in late summer the company provided EZ Way product specific training. NA-D stated information covered included positioning, strap colors and placement, time out and communication to ensure straps secured. NA-D stated size of sling needed was noted on the care sheets. During interview on 11/19/25 at 11:03 a.m., NA-F stated the facility had recently gotten new lifts. NA-F stated they received step-by-step training on the devices and slings. NA-F stated the care sheets noted the size needed by the residents. NA-F also stated, the STOP (safety program, in which a resident was raised a couple of inches to verify straps secured as tension was placed on them by the residents body weight) program had been implemented when the educational RN had started. During interview on 11/19/25 at 11:08 a.m., NA-G stated she had taken courses related to using mechanical lifts. NA-G stated the facility had implemented another safety program, in which a resident was raised a couple of inches to verify straps secured. Training was received via email, and they read the information and signed off on it. NA-G stated residents sling size was noted on the care sheet. During interview on 11/19/25 at 11:36 a.m., NA-A stated she had lifted R13 up and pulled lift backwards and sling was noted to be fine. Neither NA-A or NA-B stopped to check the sling to ensure the loops on the sling were correctly hooked on the lift bar before moving the lift away from the bed. NA-A stated the loops on the sling must not have been on the lift bar correctly and slipped causing the front right loop to detach. NA-B was behind R13 when R13 fell. NA-A stated R13 hit the right side of her head on the floor. NA-A stated she could not recall the sling size but thought a medium sling was to be used on R13 per care plan. NA-A indicated assistant director of nursing (ADON) came to facility and had staff reenact incident and provided training via competency checklist and demonstration before they had been able to work with residents again following the incident. During interview on 11/19/25 at 12:24 p.m., lift representative (LR)-D stated they were notified of the incident that occurred. LR-D stated people needed to pay attention and ensure the straps are connected to the machine and LR-D teaches staff to stop and pause once there is tension on the straps to ensure it is secure. LR-D stated staff should ensure right size slings is being utilized. LR-D confirmed additional training had been completed at the facility 8/12/25 following the incident. During interview on 11/19/25 at 1:00 p.m., assistant director of nursing (ADON)-C stated she received a phone call from the facility on 8/3/25 alerting her to R13's fall from the lift. ADON-C came to facility after the fall. ADON stated the staff was 90% certain the loop was on, and that the resident was not lifted very far, so it was a slow fall. ADON assessed R13 who was at her baseline. ADON stated staff used a small sling when a medium sling was care planned but due to R13's weight, she could have used either size sling. ADON stated all information was provided to the director of nursing (DON) and executive director (ED) to determine if it was a reportable event. During interview on 11/19/25 at 1:14 p.m., director or nursing (DON)-B stated registered nurses (RNs) determined sling size based on the (continued on next page)

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents' body size and weight. Residents were reevaluated depending on their weight and health status. If the wrong sling was used, staff must have grabbed the wrong size, as R13's sling size was indicated on the care sheet. DON-B stated the supply closets housed the extra slings for use when one was soiled or being laundered, and there was no concern of possible shortage being the cause of wrong size being used for R13. During interview on 11/19/25 at 1:34 p.m., executive director (ED)-A stated routine maintenance inspection had been completed on the lift 7/23/25 using the EZ Way routine maintenance checklist. This task had been entered into the TELS (a building management platform designed for maintenance needs in senior living communities) system to be completed annually. The facility also had purchased the preventative maintenance program with the lifts which included annual inspection and maintenance. ED-A stated facility maintenance was scheduled for July annually, and the EZ Way inspection scheduled for January, therefore the lifts would be inspected every six months and as needed. The lift involved in this fall had been pulled off the floor until maintenance was able to inspect it again on 8/3/25. ED-A stated the lifts were less than a year old. ED-A stated R13 could have used either a small or medium sling based on body weight, and she had confirmed this with EZ Way representative during the facility investigation. ED-A stated sling size can be sized down when a resident is in between sizes but should not size up. ED-A stated NAs could not determine appropriate sling size for a resident, and that it was determined by an RN and noted on the care plan, which pulled through to the care sheets. ED-A stated the fall had not been reported to the SA as it had been determined through the investigation that there had been no concern regarding abuse or neglect. The facility investigation found that the NAs took resident safety very seriously and followed the care plan and they felt they were not rushing and followed their training, there had been no supply issue with the sling, the strap coming loose was not intentional or neglectful, the staff involved had no previous care or performance concerns or incidents, R13's injury had not required treatment, R13's neurological assessments and vital readings were stable, and R13 was at baseline. ED-A also noted there had been no concerns voiced by the hospice provider or R13's guardian. ED-A verbalized incident did not clearly meet abuse reporting requirements. During interview on 11/19/25 at 2:38 p.m., DON-B explained the new program as SAFE by Leading Age. DON explained that it is very similar to what staff had previously been trained on, including the expectation of verbalizing correct strap placement and secured correctly with teammate prior to transferring resident. DON-B explained the program as more standardized, with a formal campaign to increase awareness and improve outcomes by decreasing adverse events. DON-B stated all staff will be taking the pledge that the DON's in the organization had taken over the summer. Since then, stop sign stickers had been applied to all the lifts to remind staff of the program and training. During interview on 11/20/25 at 7:43 a.m., LPN-B stated when she responded to residents' room [ROOM NUMBER]/3/25, she had been called on walkie talkie. When she entered the room, resident was laying on the floor with sling beneath her, lift legs were together and one of residents' legs was over the lift legs. LPN- B was not able to recall which leg. LPN-B stated R13 did not appear to be in distress. LPN-B stated after getting resident up and checking her over and obtaining vitals, she called hospice and the on-call RN who came in a short time later. LPN-B stated she then pulled the lift off the floor. NA-A and NA-B were pulled off the floor and advised to write their statements of the incident. LPN-B stated both NAs appeared to be anxious and didn't know how the fall occurred. Facility provided training documents for NA-A and NA-B completed 8/3/25 and again 8/16/25, included lift competency guidelines and checklist total mechanical lift (Hoyer) steps instructed to always verify correct sling size, and ensure all loops secured. In addition, safe transfer competency exams were included for both NA-A and NA-B.Facility Safe-Patient-Handling Program training log dated 11/4/24, for in person training completed with EZ Way Rep for facility staff at the time of new lifts being implemented indicated 21 staff had attended. Facility Safe-Patient-Handling Program training log dated 8/12/24, for in person training completed with EZ Way Rep for facility staff at the time of new lifts being implemented indicated 24 staff had attended. Facility Policy No. POL_SS018, no date, titled Abuse Prevention Plan, page 5, paragraph B, (continued on next page)

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	under Reporting of Suspected Resident Abuse and/or Neglect, indicated events in which abuse was not suspected and did not result in bodily injury, it was required to report the incident no later than 24 hours after, also if the event was suspected to be the result of abuse/neglect or resulted in serious bodily injury to report immediately, but no later than 24 hours after.Facility Policy No: POL_NS 803, last revised 9/30/24, titled Using a mechanical lift, indicated resident be measured for proper sling size and purpose, according to manufacturer's instructions. In addition, step 11 in the procedure instructed to attach the sling straps to sling bar clips, before resident was lifted ensuring security of the sling attachment, while also visualizing the fasteners and security. Step 12 instructed to lift resident approximately 2 inches from the surface to check stability and fit of sling prior to lifting further.EZ-Way Smart Life Operator's Instructions revised 5/9/25, indicated EZ Way slings were made specifically for EZ Way Smart Lifts. For the safety of the patient and the caregiver, only EZ Way slings should be used with EZ Way lifts. Instructions also indicate that a small sling should be used for resident who weigh 70-100 lbs. Residents who weight 90-220 lbs. should use a medium sling. Instructions indicated staff should make a final check of all four loop attachment points to ensure each loop is sufficiently attached to the respective hood of the hanger bars. Patient is ready to be lifted. Additionally, instructions indicated staff to push the up button on the hand control to initiate the upward motion until there is tension on the slings legs, making sure all the loops on the sling are securely hooked on the hanger bar prior to advancing. EZ-Way Sling Color Coding System not dated, listed gray as the color for a size small sling for resident weights 70-100 pounds, with a maximum distance from tailbone to base of neck being 21 inches. A medium sling indicated as beige in color, for resident weight 90-220 pounds, with a maximum distance from tailbone to base of neck being 24 inches.

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure staff assisted residents with eating in a manner that supported dignity for 5 of 5 residents (R2, R13, R43, R44, and R51) reviewed for dining assistance. Specifically, staff stood over residents while feeding them, rather than assisting them at eye level, which compromised dignity and created the potential for discomfort, decreased meal satisfaction, and a lack of person-centered dining support.Findings include:During observations of the evening meal on 11/18/25 and the breakfast meal on 11/19/25, staff were observed standing next to R2, R13, R43, R44, and R51-who were seated in their wheelchairs in the dining room-while assisting them with eating. R2During observation of the breakfast meal service on 11/19/25 at 8:54 a.m., an unidentified nurse assisted R2 with Jello while standing beside her. At 8:59 a.m., nursing assistant (NA)-J assisted R2 with oatmeal while standing directly over her, leaning down to place the spoon in R2's mouth. At no time did staff sit or kneel to provide eye-level assistance. Record review of R2's care plan indicated R2 required extensive assistance with eating due to impaired cognition. R13During breakfast meal observation on 11/19/25 at 8:41 a.m., NA-H was observed assisting R13 with breakfast while standing upright at the side of R13's wheelchair. R13 looked upward toward NA-H during each bite. NA-H did not attempt to sit or lower herself to R13's level during the interaction. Record review of R13's care plan indicated R13 required extensive assistance with eating due to impaired cognition. R43At 8:47 a.m., NA-K was observed assisting R43 with eating while standing. NA-K did not attempt to sit or lower herself to R43's level during the interaction and remained standing throughout the feeding interaction. Record review of R43's care plan indicated R43 required assistance with eating due to physical decline and advanced dementia. R44At 8:52 a.m., NA-I was observed assisting R44 with eating while standing. NA-I did not attempt to sit or lower herself to R44's level during the interaction and remained standing throughout the feeding interaction. Record review of R44's care plan indicated R44 required assistance with eating due to left-sided weakness and impaired cognition. R51At 8:56 a.m., NA-J was observed assisting R51 with eating while standing. NA-J did not attempt to sit or lower herself to R51's level during the interaction and remained standing throughout the feeding interaction. Record review of R51's care plan indicated R51 required assistance with eating due to normal pressure hydrocephalus (a neurological condition causing gait disturbance, memory issues, and slowed processing), weakness (reduced physical strength), and impaired cognition (difficulty with memory, attention, or problem-solving). During an interview on 11/20/25 at 1:20 p.m., NA-H stated all aides stand next to residents in the dining room when assisting them with eating. During an interview on 11/20/25 at 1:22 p.m., NA-I stated staff are expected to stand next to the resident they are assisting with eating when in the dining room. During an interview on 11/20/25 at 1:38 p.m., RN Clinical Manager (RN)-A stated staff were expected to assist residents at eye level because standing over residents can feel rushed, intimidating, or uncomfortable for them. During an interview on 11/20/25 at 3:16 p.m., the Director of Nursing (DON) stated the expectation was that staff would ensure a dignified dining experience and sit at eye level during feeding. After reviewing the observations, the DON stated, Standing over residents to feed them should not be happening. That is not dignified care. The facility's policy titled Assistance with Meals, dated 2/2018, indicated residents who cannot feed themselves will be assisted with attention to safety, comfort and dignity.

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure the pneumococcal conjugate vaccine (PCV20) was offered to 4 of 5 residents (R34, R37, R39, and R48) reviewed for pneumococcal immunization. Specifically, each resident had signed consent for pneumococcal vaccination; however, the facility failed to assess eligibility and offer PCV20 in accordance with CDC and facility immunization guidelines. This failure resulted in missed vaccination opportunities and increased the risk for preventable pneumococcal disease.Findings include:R34Record review of R34's electronic medical record on 11/20/25 revealed R34 had diagnoses including metabolic encephalopathy (acute or chronic brain dysfunction caused by metabolic imbalance), type 2 diabetes mellitus (a metabolic disorder causing elevated blood glucose), paroxysmal atrial fibrillation (irregular heart rhythm that occurs intermittently), and chronic kidney disease (long-term reduced kidney function), placing R34 at increased risk for pneumococcal infection. Review of the Pneumococcal Vaccine Consent/Declination form showed R34 had signed consent for pneumococcal vaccination. Review of R34's Immunization Record indicated no documentation of PCV20 administration and no evidence the vaccine had been offered. The last pneumococcal vaccine documented was PPSV23 on 8/28/18, with no follow-up vaccination. R37Record review of R37's electronic medical record on 11/20/25 revealed R37 had diagnoses including type 2 diabetes mellitus, vascular parkinsonism (movement disorder caused by reduced blood flow in the brain), hypertension (chronically elevated blood pressure), and respiratory bronchiolitis interstitial lung disease (lung condition causing inflammation and scarring of airways and lung tissue), placing R37 at increased risk for pneumococcal infection. Review of the Pneumococcal Vaccine Consent/Declination form, dated 3/19/25, showed R37's representative had signed consent for pneumococcal vaccination if/when eligible. Review of R37's Immunization Record indicated no documentation of PCV20 administration and no evidence the vaccine had been offered. The last pneumococcal vaccine documented was PCV13 on 9/28/15, with no follow-up vaccination. R39Record review of R39's electronic medical record on 11/20/25 revealed R39 had diagnoses including hypertensive chronic kidney disease (kidney damage caused by long-term high blood pressure), acute pyelonephritis (sudden bacterial infection of the kidneys), and paroxysmal atrial fibrillation, placing R39 at increased risk for pneumococcal infection. Review of the Pneumococcal Vaccine Consent/Declination form, dated 9/29/25, showed R39 had signed consent for pneumococcal vaccination if/when eligible. Review of R39's Immunization Record indicated no documentation of PCV20 administration and no evidence the vaccine had been offered. The last pneumococcal vaccine documented was PCV13 on 3/25/16, with no follow-up vaccination. R48Record review of R48's electronic medical record on 11/20/25 revealed R48 had diagnoses including metabolic encephalopathy, severe sepsis with septic shock (life-threatening infection causing organ dysfunction and dangerously low blood pressure), heart failure (reduced ability of the heart to pump blood effectively), paroxysmal atrial fibrillation, and cerebral infarction (stroke caused by reduced blood flow to the brain), placing R48 at increased risk for pneumococcal infection. Review of the Pneumococcal Vaccine Consent/Declination form, dated 10/28/25, showed R48's representative had signed consent for pneumococcal vaccination if/when eligible. Review of R48's Immunization Record indicated no documentation of PCV20 administration and no evidence the vaccine had been offered. The last pneumococcal vaccine documented was PCV13 on 11/11/16, with no follow-up vaccination. During an interview on 11/20/25 at 2:39 p.m., Infection Preventionist (IP)-A stated she reviewed each resident's immunizations quarterly and used the PneumoRec App on her phone to determine eligibility for pneumococcal vaccines. IP-A entered information in the app for R34, R37, R39, and R48 and confirmed all four residents should have been offered PCV20. IP-A stated, I didn't really read all of the paragraph, I guess-just the part that stated that if a resident had PPSV23 and PCV13 they would be considered complete. IP-A stated the facility was expected to offer vaccinations to all eligible residents and confirmed all four residents had signed consent but were never offered the vaccine. (continued on next page)

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IP-A stated, If they've signed consent, they should be offered the vaccine. During an interview on 11/20/25 at 3:11 p.m., the Director of Nursing (DON) stated the expectation was that residents with signed consent must be offered the vaccine unless a contraindication or refusal occurred. Review of the facility's policy titled Pneumococcal Vaccines for Residents, last revised 2/7/25, indicated the facility would provide education and administration of pneumococcal vaccines (PPSV23 and PCV13) to residents according to CDC recommendations.

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to the State Agency (SA), as required by federal regulations, a fall involving a mechanical lift transfer, an incident that may indicate potential neglect. This deficient practice affected 1 of 1 residents (R13) reviewed for fall from mechanical lift, however it had the potential to affect all residents requiring the use of mechanical lift for transfers. Findings include:R13's quarterly Minimum Data Set (MDS) dated [DATE], indicated R13 had severely impaired cognition, needed extensive assistance with two people for transfers and R13 had a prognosis that indicated a life expectancy of less than six months, including: progressive supranuclear ophthalmoplegia (progressive damage to brain cells that leads to motor and non-motor symptoms), unspecified dementia with psychotic disturbance, and type II diabetes mellitus (DM) with other circulatory complications.R13's care plan dated 3/21/25, indicated R13 needed a mechanical lift with two staff assistance for transfers.Care sheet indicated R13 used a size medium sling.R13's medical record lacked evidence that a sling assessment had been completed. R13's weight on 7/16/25 was 124.8 lbs.R13's fall investigation report dated 8/3/25, indicated R13 was being transferred with an EZ Way smart lift from her bed to wheelchair. Staff noted they connected straps on the mechanical lift hooks, crossed the bottom strap between the resident's legs and appropriately attached to lift as well. Staff noted that once R13 was suspended in the air, not over the bed, they noted the strap by R13's left shoulder was not attached to lift. R13 began to slip out of the sling and fell to the floor hitting her head. R13 sustained abrasion to the posterior, right side of head. Report indicated no unsafe practices occurred in the reenactment of transfer. Assistant director of nursing (ADON) determined staff was utilizing a small sling verses a medium sling per care plan.During interview on 11/19/25 at 11:36 a.m., NA-A stated she had lifted R13 up and pulled lift backwards and sling was noted to be fine. NA-A stated it must not have been on correctly and slipped causing the front right loop to detach. NA-B was behind R13 when R13 fell. NA-A stated R13 hit the right side of her head on the floor. NA-A stated she could not recall the sling size but thought a medium sling was to be used on R13 per care plan. NA-A indicated assistant director of nursing (ADON) came to facility and had staff reenact incident and provided training via competency checklist and demonstration before they had been able to work with residents again following the incident. During interview on 11/19/25 at 1:00 p.m., assistant director of nursing (ADON)-C stated she received a phone call and came to facility after the fall. ADON stated the staff was 90% certain the loop was on, and that the resident was not lifted very far, so it was a slow fall. ADON assessed R13 who was at her baseline. ADON stated staff used a small sling when a medium sling was care planned but due to R13's weight, she could have used either size sling. ADON stated all information was provided to the director of nursing (DON) and executive director (ED) to determine if it was a reportable event. During interview on 11/19/25 at 1:34 p.m., executive director (ED)-A stated stated the fall had not been reported to the SA as it had been determined through the investigation that there had been no concern regarding abuse or neglect. The facility investigation found that the NAs took resident safety very seriously and followed the care plan and they felt they were not rushing and followed their training, there had been no supply issue with the sling, the strap coming loose was not intentional or neglectful, the staff involved had no previous care or performance concerns or incidents, R13's injury had not required treatment, R13's neurological assessments and vital readings were stable, and R13 was at baseline. ED-A also noted there had been no concerns voiced by the hospice provider or R13's guardian. ED-A verbalized incident did not clearly meet abuse reporting requirements. Facility Policy No. POL_SS018 titled Abuse Prevention Plan, page 5, paragraph B, under Reporting of Suspected Resident Abuse and/or Neglect, indicated events in which abuse was not suspected and did not result in bodily injury, it was required to report the incident no later than 24 hours after, also if the event was suspected to (continued on next page)

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be the result of abuse/neglect or resulted in serious bodily injury to report immediately, but no later than 24 hours after.

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive, person-centered care plan was developed and maintained to address a resident's cardiac condition and implanted pacemaker for 1 of 1 resident (R10) reviewed for cardiac devices. The failure to include the resident's pacemaker in the care plan created the potential for inadequate monitoring, delayed identification of complications, inappropriate interventions during emergencies, and failure to communicate essential information to direct care staff.Findings include: R10's quarterly Minimum Data Set (MDS) dated [DATE] identified R10 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R10's diagnoses included non-traumatic brain dysfunction (brain impairment not caused by external injury), heart failure (the heart's reduced ability to pump effectively), hypertension (elevated blood pressure), renal failure (impaired kidney function), diabetes mellitus (a metabolic disorder causing elevated blood glucose), non-Alzheimer's dementia (progressive decline in memory, thinking, or behavior not related to Alzheimer's disease), hemiplegia (paralysis affecting one side of the body), seizure disorder (neurological condition causing recurrent seizures), anxiety disorder (persistent excessive worry or fear) and bipolar disorder (mood disorder involving episodes of depression and elevated or irritable mood). The MDS also indicated R10 had a pacemaker (an implanted device that regulates heart rhythm). Review of R10's individualized care plan, print date of 11/20/25, revealed no care plan problem, goal, or intervention related to R10's implanted pacemaker. There was no documentation addressing monitoring of heart rate or rhythm concerns, signs of pacemaker malfunction, activity precautions, emergency response considerations, or the need for staff to report symptoms such as dizziness, syncope, palpitations, or chest discomfort. Review of R10's Vitals flow sheets for June through October 2025 identified routine vital signs had been documented, but there was no evidence of any monitoring specifically associated with pacemaker function or related cardiac assessments. Review of R10's Provider Orders revealed ongoing orders for the cardiac medication amlodipine. However, there were no corresponding care plan interventions to guide staff regarding enhanced monitoring, parameters for reporting changes, or recognition of complications in a resident with a pacemaker. During an interview on 11/20/25 at 2:59 p.m., the Assistant Director of Nursing (ADON) acknowledged there were no individualized care plan items describing the pacemaker, its purpose, or related precautions. The ADON stated the pacemaker should be addressed in the care plan, so staff are aware of it and know how to respond appropriately. During an interview on 11/20/25 at 3:16 p.m., the Director of Nursing (DON) confirmed the facility expected care plans to include specific medical devices such as pacemakers, including monitoring needs and emergency considerations. The DON stated the pacemaker should definitely be in the care plan because it affects how staff monitor and respond to the resident. The facility's policy titled Comprehensive Assessments and Care Planning, dated 9/27/23, indicated the care plan reflects the resident's stated goals and objectives and includes interventions that address his or her current needs.

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided timely and adequate assistance with eating for 1 of 5 residents (R2) reviewed for dining assistance. Specifically, staff failed to assist a dependent resident within an appropriate timeframe, resulting in the resident's meal becoming cold before assistance was provided. This deficient practice created the potential for reduced nutritional intake, decreased meal satisfaction, and compromised dignity.Findings include: R2's quarterly Minimum Data Set (MDS) dated [DATE] identified R2 had impaired cognition and required assistance with activities of daily living (ADLs). R2's diagnoses included neurocognitive disorder with Lewy bodies (a progressive brain disease causing cognitive decline, visual hallucinations, and movement difficulties), arthritis (inflammation of the joints causing pain and decreased mobility), non-Alzheimer's dementia (cognitive decline due to causes other than Alzheimer's disease), and anxiety disorder (a mental health condition characterized by excessive worry, fear, or nervousness). R2's care plan indicated R2 required staff to provide total assistance with eating due to impaired cognition. During observation of the breakfast meal service on 11/19/25 at 8:35 a.m., R2 was seated in the dining room with her meal placed in front of her. The meal consisted of a bowl of oatmeal, a Jello cup, and juice. During continuous observation from 8:35 a.m. to 8:54 a.m., no staff approached R2 to provide assistance with her meal. R2 remained seated with her tray untouched. Steam was no longer visible from the food after several minutes, and by 8:51 a.m., the food appeared visibly cooled and congealed. At 8:54 a.m., an unidentified nurse approached R2 and started to assist her with a container of Jello. Once R2 was finished with the Jello, the nurse left R2 with the oatmeal sitting in front of her. R2 looked at the food and then looked toward staff. At 8:59 a.m., nursing assistant (NA)-K approached R2 and started to assist her with eating the bowl of cold oatmeal, which appeared thick and stiff when the NA was stirring it. During an interview on 11/19/25 at 10:02 a.m., NA-K stated, We were short today, and I didn't get to her in time. I know her food gets cold fast if she can't start eating right away. NA-K acknowledged R2 required staff to feed her immediately after the meal was served. During an interview on 11/20/25 at 1:38 p.m., Clinical Manager (CM)-A stated the resident required full assistance with eating. CM-A stated dependent residents should be assisted first so food remained warm when eating. CM-A stated staff should stay with the resident they were assisting until the resident was finished eating unless there was an emergency situation. CM-A stated when staff assisted residents, staff should be at the same eye level as the resident for comfort and a home-like atmosphere. During an interview on 11/20/25 at 3:16 p.m., the Director of Nursing (DON) stated the expectation was that dependent residents were to be assisted with eating as soon as their meals were delivered. The DON reviewed the observation timeline and stated, She should not have been waiting that long. Her food should not have been cold before staff helped her. Facility policy was requested but was not received.

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	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Assumption Home	715 North First Street Cold Spring, MN 56320

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure a COVID-19 booster vaccination was administered as consented for 1 of 5 residents (R37) reviewed for immunization. Specifically, the facility obtained documented consent for a COVID-19 booster but failed to administer the vaccine, resulting in a missed immunization opportunity and potential increased risk for preventable illness.Findings include: Record review of R37's electronic medical record on 11/20/25 revealed R37 had diagnoses including hypertension (high blood pressure that increases cardiovascular risk), hydrocephalus (abnormal accumulation of cerebrospinal fluid in the brain), respiratory bronchiolitis interstitial lung disease (a chronic lung disorder causing inflammation and scarring that affects breathing efficiency), and diabetes mellitus (a metabolic disorder characterized by elevated blood glucose). These conditions placed the resident at increased risk for complications from COVID-19 infection. Review of the facility's COVID-19 Vaccine Consent/Declination form, dated 9/18/25, revealed R37 had provided written consent to receive the 2025-2026 COVID-19 booster. The form was signed by R37's representative but lacked signature by a facility nurse. Further review of the Immunization Record and Vaccine Administration Log for September, October, and November 2025 revealed no documentation R37 received the COVID-19 booster. The immunization record indicated the COVID-19 vaccine was last received on 11/15/22 outside of the facility. During an interview on 11/20/25 at 2:39 p.m., Infection Preventionist (IP)-A reviewed R37's immunization record and stated, She should have received the booster. If she consented, it should be documented as administered or there should be a reason why it wasn't. IP-A stated the expectation was all consented residents were to be vaccinated as soon as possible, noting the facility could obtain vaccination from the pharmacy the same day. IP-A confirmed there was no documentation of any reason the booster was not given. During an interview on 11/20/25 at 3:16 p.m., the Director of Nursing (DON) stated the facility followed protocols requiring timely administration and documentation of COVID-19 vaccinations. The DON stated, If a resident consents, we must give the booster unless there's a clear medical reason not to. In this case, it looks like we missed it. Review of the facility's policy titled COVID-19 Vaccine and Booster for Residents, last revised 12/23, indicated all eligible residents were to be offered the COVID-19 vaccination and booster doses when available.