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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 2C84
Facility ID: 00758

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245304**

2. STATE VENDOR OR MEDICAID NO. (L2) **847972200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE GARDENS AT CANNON FALLS**
(L4) **300 NORTH DOW STREET**
(L5) **CANNON FALLS, MN** (L6) **55009**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **12/20/2013**

6. DATE OF SURVEY **02/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **74** (L18)
13.Total Certified Beds **74** (L17)

10.THE FACILITY IS CERTIFIED AS:
x A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 74 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 04/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00270** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245304

April 6, 2017

Mr. Thomas Paul, Administrator
The Gardens At Cannon Falls
300 North Dow Street
Cannon Falls, MN 55009

Dear Mr. Paul:

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

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

Effective February 15, 2017 the above facility is certified for:

74 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 74 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 22, 2017

Mr. Thomas Paul, Administrator
The Gardens At Cannon Falls
300 North Dow Street
Cannon Falls, MN 55009

RE: Project Numbers S5304026, H5304036

Dear Mr. Paul:

On December 16, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring, effective December 21, 2016. (42 CFR 488.422)

In addition, on December 16, 2016 we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 1, 2017. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on December 1, 2016 that included an investigation of complaint number H5304036. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 19, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2017. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016.

As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

Also, in our letter of January 27, 2017, we notified you that this Department recommended to the CMS Region V Office the following actions related to the enforcement remedies in our letter of December 16, 2016:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

In addition, on January 27, 2017, as authorized by CMS, we informed you that the following remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 1, 2017. (42 CFR 488.417 (b))

On February 27, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 19, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 15, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 19, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 15, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 1, 2017 be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 1, 2017 is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 1, 2017, is to be rescinded.

The CMS Region V Office will notify you of their determination regarding our recommended remedies and Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION A. Building B. Wing (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 245304 | | 2/27/2017 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET<br>CANNON FALLS, MN 55009 |

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).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix F0253<br>Reg. # 483.10(i)(2)<br>LSC | Correction Completed 02/15/2017 | ID Prefix F0318<br>Reg. # 483.25(c)(2)(3)<br>LSC | Correction Completed 02/15/2017 | ID Prefix F0334<br>Reg. # 483.80(d)(1)(2)<br>LSC | Correction Completed 02/15/2017 |
| ID Prefix F0441<br>Reg. # 483.80(a)(1)(2)(4)(e)(f)<br>LSC | Correction Completed 02/15/2017 | ID Prefix F0520<br>Reg. # 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i)<br>LSC | Correction Completed 02/15/2017 | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) GPN/kfd | DATE 3/13/2017 | SIGNATURE OF SURVEYOR 15425 | DATE 2/27/2017 |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |
|---|---|
| 12/1/2016 | |

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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Facility ID: 00758

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(L4) **300 NORTH DOW STREET**
(L5) **CANNON FALLS, MN** (L6) **55009**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **12/20/2013**

6. DATE OF SURVEY **01/19/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **74** (L18)

13.Total Certified Beds **74** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 74 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Sarah Strenke, HFE NE II 04/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/05/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00270** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

January 27, 2017

Mr. Thomas Paul, Administrator
The Gardens At Cannon Falls
300 North Dow Street
Cannon Falls, MN 55009

RE: Project Number S5304026 and Complaint Number H5304036

Dear Mr. Paul:

On December 16, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 21, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on December 1, 2016 that included an investigation of complaint numbers H5304033 and H5304034 that were found to be unsubstantiated and H5304036 that was found substantiated and cited at F309. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 19, 2017, the Minnesota Department of Health and on January 10, 2017, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2017. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on December 1, 2016. The deficiencies not corrected are as follows:

F253 -- S/S: E -- 483.10(i)(2) -- Housekeeping & Maintenance Services
F318 -- S/S: D -- 483.25(c)(2)(3) -- Increase/prevent Decrease In Range Of Motion
F334 -- S/S: E -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations
F441 -- S/S: F -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Control, Prevent Spread, Linens

In addition, at the time of this revisit, we identified the following deficiency:

F520 -- S/S: F -- 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) -- Qaa Committee-Members/meet Quarterly/plans

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

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 1, 2017. (42 CFR 488.417 (b))

In addition, this Department recommended to the CMS Region V Office the following actions:

- Per day civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of December 16, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 1, 2017.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include electronic acknowledgement signature of provider and date.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov

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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245304 | A. BUILDING ______<br>B. WING ______ | R<br>01/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET<br>CANNON FALLS, MN 55009 |

| (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<br><br>An onsite post certification revisit (PCR) was completed on January 17, 18, & 19, 2017. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of onsite PCR which are located on the CMS2567.<br><br>During the PCR a complaint H5304036 which had been substantiated at F309 is now found corrected.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | {F 000} | | |
| {F 253}<br>SS=E | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to maintain a clean, sanitary environment, and resident rooms in good repair, for residents, staff and visitors. This had the potential to affect all 61 residents in the facility.<br><br>Findings include: | {F 253} | A review has been done by the maintenance director throughout the facility to observe for any other problems similar to those cited under this tag; corrections are being made as required. Facility staff have been trained on the facility corrections under this citation and | 2/15/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/03/2017

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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| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET** **CANNON FALLS, MN 55009** |

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| {F 253} | Continued From page 1<br><br>Observations during the initial environment tour on 1/18/17, at 9:03 a.m., revealed the following:<br><br>On the 100 wing:<br>There were two window blinds broken in room 121.<br><br>On the 200 wing:<br>Torn wall paper in hallway between rooms 209 and 211, and 225 and 227, revealing the wallboard below; strong urine odor in hallway; stained carpet at 200 wing desk; hallway carpet in front of room 228 with a 12 inch stain on carpet; room 221 bathroom-brown stained linoleum around toilet and very strong urine odor; and room 227 with missing blind towards head of bed.<br><br>On the 300 wing:<br>Broken window blind in room 309, verified by licensed practical nurse (LPN)-B at the time of the tour; strong urine odor in throughout the hallway; lower edges of both sides of archway between dining room and living room-missing paint and plaster; scratches on full width of activities closet door,located in the dining room. During interview at that time, LPN-B stated not aware of how long the scratches had been there.<br><br>Two main dining rooms had broken ceiling tiles.<br><br>During interview on 1/18/17, at 9:11 a.m., LPN-B was asked what was the protocol for reporting environmental concerns to be repaired, LPN-B stated if need repairs, would let maintenance department know in the maintenance communication book. LPN-B verified there was no entry in the communication book for repair of the lower edges of the archway and for scratches | {F 253} | to report any problems based on the physical plant to maintenance for repair. They have been trained on reporting through the maintenance problem log on the units.<br>Corrections have been made as followed based on the citations:<br>" Room 121 Two broken window blinds repaired<br>" Rooms 209 □ 211 and 225 □ 227 Walls paper rips have been repaired between these rooms in the hallway<br>" Urine odor in 200 hallway has been corrected by addressing the source which is in the rooms.<br>" 200 hall □ stained carpet at nurse□s station cleaned<br>" Room 221, new flooring put down in bathroom<br>" Room 221 urine smell corrected<br>" Room 227 Missing blinds replaced<br>" Room 309 blinds fixed<br>" 300 wing: Strong urine smell eradicated<br>" Lower edges of archway between dining room and living room on 300 wing fixed □ scratches and painting<br>" 300 Wing activities door scratches are fixed<br>" (2) ceiling tiles in main dining room are fixed<br>Audit: The facility ED will review corrections to the physical plant and ensure that the corrections in this citation and any similar problems are being managed in a timely manner by the maintenance department. The ED will report quarterly to the QA Committee on this program. | |

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{F 253} Continued From page 2 {F 253}

on activities closet door.

R42 stated during interview on 1/18/17 at 2:00 p.m., the hall smelled of strong urine and it is worse in the summer. After a while you become "nose blind" to it. The air conditioning doesn't work well in the summer and the urine smell is "awful."

During environmental tour with environmental director (ED) on 1/18/17, at 3:00 p.m., the above observations were verified. ED stated there was a maintenance communication book on each of three wings and at the front lobby desk, for staff to write needed repairs. ED verified not aware of 300 wing archway missing plaster and activity closet door scratches. ED identified the torn wall paper between rooms 225 and 227, as about three inch tear. ED verified the torn wallpaper between rooms 209 and 211 had been repaired that day.

Although a policy for maintenance of the facility was requested, none was provided.

{F 318} SS=D 483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION {F 318} 2/15/17

(c) Mobility.

(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum

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| {F 318} | Continued From page 3<br>practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure range of motion (ROM) exercises were performed as recommended by the physical therapist (PT) for 2 of 3 residents (R13 and R42) reviewed for ROM.<br>Findings include:<br>R13 diagnosis found on the treatment record dated January 2017 indicates multiple sclerosis (MS), Type 2 diabetes mellitus with diabetic polyneuropathy and generalized muscle weakness.<br>R13's treatment administration record does not indicate any ROM services.<br>R13's aide care flowsheet dated January 2017 indicates R13 to receive functional nursing program to include passive range of motion to bilateral lower extremities X 10 repetitions to each joint one time daily. Position feet back in foot buckets on wheelchair. Review of form indicating this was done 1 out of 19 days (1/15/17) for the month of January.<br>R13's progress notes reviewed from 1/10/17 to 1/19/17 does not indicate any refusals of ROM exercises or reasons not to complete the daily ROM.<br>R13's Care Area Assessment (CAA) worksheet dated 4/11/16, indicates R13 to have progressive multiple sclerosis (MS) and requires staff to assist with his activities of daily living (ADLs). R13 requires two staff for bed mobility, transfers and dressing. R13 transfers with a Hoyer lift. R13 is non ambulatory and uses an electric wheelchair for all mobility. R13 is noted to have limited ROM to his left upper extremity due to MS. CAA does not identify the limited ROM to bilateral lower | {F 318} | ROM has been set up and is being performed for Residents #13 and #42.<br>Floor nurse and nurse manager, to ensure compliance with ROM programs, will review checklist, perform random ROM observations for compliance, and nurse managers will document in the residents' records weekly.<br>A review has been done to ensure that any other resident at the facility who is ordered to have ROM is getting ROM.<br>Nursing staff will be trained by 2-3-17 on ensuring ROM exercises are done as per physician ordered and on the updated ROM policy. They will also be trained on the new ROM calendar explained below.<br>A new ROM calendar has been developed and the IDT updated this with ROM exercises for residents based on physician orders. This calendar is made available to PT and Nursing so that it can be followed daily. The DON or her designee (in conjunction with PT) ensures that the calendar is updated every morning in the morning meeting and delivered to the units. During the day, as ROM is provided, staff members cross off the completed ROM exercises based on the name of the resident listed on the calendar. The policy on ROM will be updated to reflect the use of this ROM calendar.<br>The DON or her designees will conduct an audit weekly x 4 and then monthly thereafter of the calendar being used on | |

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| {F 318} | Continued From page 4<br>extremities even though it was present during this assessment period.<br>R13's quarterly Minimum Data Set (MDS) dated 12/8/16, indicates R13 to have a BIMS score of 15/15 indicating no cognitive impairment.<br>Interview on 1/18/17, at 2:10 p.m. with R13. R13 stated he had not received ROM therapy services for a long time and when asked stated staff never perform any ROM exercises to his lower extremities.<br>Interview on 1/18/17, at 2:27 p.m. with the director of admissions and staff development, verified R13 was on a functional maintenance program and was to receive ROM one time daily from the nursing assistants.<br>Observation of morning cares on 1/19/17, from 7:18 a.m. until 7:38 a.m. with nursing assistant (NA)-A, ROM exercises were not completed for R13.<br>Interview on 1/19/17, at 7:53 a.m. with NA-A stated he doesn't complete ROM for R13 and was unaware he needed to. NA-A said her would as the nurse if he should be doing ROM for R13.<br>Interview on 1/19/17, at 7:54 a.m. with licensed practical nurse (LPN)-A stated R13 should have ROM exercises completed daily. LPN-A stated R13 usually refuses ROM and when asked where the refusals are documented stated she was unaware of where the refusals were and should be documented.<br>Interview on 1/19/17, at 10:02 a.m. with physical therapist assistant (PTA) verified the nursing assistants were responsible to complete ROM exercises daily for R13.<br>Interview on 1/19/17, at 12:03 p.m. with the therapy program manager (TPM) stated R13 should be receiving ROM exercises daily. TPM stated there are no spot checks to see if ROM is being completed and there is no follow up to | {F 318} | all (3) units (a separate calendar for each unit) to ensure accuracy of the calendar compared to ROM being provided. The DON will report quarterly to the QA Committee on this program. | |

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| {F 318} | Continued From page 5<br>ensure that ROM exercises are being completed for residents.<br>Policy titled, "Range of Motion Exercises" undated and missing pages identifies, "the purpose of this procedure is to exercise the resident's joints and muscles". Policy does not identify when ROM exercises should be completed, who should receive services or who should perform exercises.<br><br>R42's face sheet, dated 1/19/17, identified a diagnosis of paraplegia. R42's annual Minimum Data Set (MDS) assessment dated 9/23/16, indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The MDS also identified R42 required extensive to total assistance with activities of daily living and had impairments in range of motion to both lower extremities.<br><br>R42's care area assessment (CAA) for ROM indicated R42 was totally dependent upon staff for transfers and was only able to be out of bed one hour daily due to a pressure ulcer. The CAA identified R42 had little to no voluntary movement in the bilateral lower extremities, was extensively dependent on staff in all ADLs and was alert and oriented. Proceed to care plan to maintain current level of functioning.<br><br>R42's care plan dated 12/6/16, indicated R42 had limited range of motion to the left hand secondary to paraplegia and non-use. The care plan identified R42 had multiple restorative programs in place but exhibited non-compliance and nearly daily refusals. No program was listed for lower extremity range of motion on the care plan. | {F 318} | | |

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| {F 318} | Continued From page 6 | {F 318} | | |

Continued From page 6

Nursing assistant (NA)-D and NA-E was observed providing morning cares for R42 on 1/19/17, at 10:40 a.m. NA-D and NA-E both stated that they cannot recall the last time passive rang of motion (PROM) had been provided to R42 due to lack of time. At the same time R42 stated 10:42 a.m. she had not had range of motion to her legs since August of 2016.

A copy of the treatment administration record (TAR) for the month of January 2017 was reviewed. On page 4 of 10 the following treatment with a start date of 8/20/16, "perform PROM [passive range of motion] bilateral foot, ankle, knees and hip internal/external rotation and hip abduction 10 times each with gentle HC stretching x 30 seconds. Program in binder hanging on closet, initial calendar when completed. To be done 3 times per seek on Sunday, Tuesday and Friday, in the morning."

The treatment administration record had ROM for R42 completed 4 out of 19 opportunities in January 2017. There was check mark on January 11, 12, 13, and 15, 2017.

The calendar hanging on the back of R42's door to enter the room is from September 2016. The calendar was blank, no initials from staff that indicated PROM had been done.

A copy of the calendar in R42's room was requested but not received.

Trained medication assistant (TMA)-D was interviewed on 1/19/17, at 7:17 a.m. regarding the PROM for R42. TMA-D stated, "I have seen it done on her hands, can't say I have seen it done on her legs."

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| {F 318} | Continued From page 7 | {F 318} | | |

Physical therapy assistant (PTA)-A was interviewed on 1/19/17, at 10:06 a.m. PTA-A stated she had not worked with R42 for over a year and there is a Function Maintenance Program (FMP) in place which is to be done by nursing.

PTA-B was interviewed on 1/19/17, at 12:04 p.m. PTA-B indicated there was no request to evaluate or treat R42 in the past month. PTA-B stated R42 had not been seen by physical therapy since 8/2016.

R42's functional maintenance program recommendations, dated 8/19/16 indicated staff to perform passive range of motion (PROM) bilateral foot, ankle, knees and hip internal/external rotation and hip abduction/adduction x 10 repetitions each side. Program is located in binder hanging on the back of door in R42's room had directions to use calendar when completed. PROM to be done 3 x/week on Sunday, Tuesday, Friday.

The facility policy entitled Range of Motion Exercises, undated indicated the date and time the exercises were performed, name of the individual who performed the procedure, type of range of motion exercise given, whether the exercise was passive or active, length of the exercise and how the resident participated in the procedure, problems or complaints made by the resident and resident refusals should be documented in the medical record.

The Chief Executive Officer (CEO) was interviewed on 1/19/17, at 11:31 a.m. as the director of nursing was not available during this

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| {F 318} | Continued From page 8<br>post certification review (PCR). The CEO was unable to locate audits related to the PROM for R42 as it was issued on the recertification survey exited 12/1/16. The CEO stated the plan of correction should have been in place related to the PROM services for residents. | {F 318} | | |
| {F 334} SS=E | 483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>(d) Influenza and pneumococcal immunizations<br><br>(1) Influenza. The facility must develop policies and procedures to ensure that-<br><br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br><br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br><br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br><br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br><br>(B) That the resident either received the influenza | {F 334} | | 2/15/17 |

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| {F 334} | Continued From page 9<br>immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br><br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br><br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br><br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br><br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br><br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to implement the Center for Disease Control and Prevention (CDC) guidelines related | {F 334} | Residents #106 and #108 had had the PCV13 offered to them and administered as required. | |

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| {F 334} | Continued From page 10<br>to pneumococcal conjugate vaccine (PCV13) for 2 of 3 residents (R106, R108) whose vaccination histories were reviewed.<br><br>Findings include:<br><br>Center for Disease Control and Prevention (CDC) identified, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose."<br><br>R106, 75 years old, was admitted to the facility 1/13/17, according to facility Nursing Admission Admitting Nurse Part 1/Day 1 Version 1.4, Data Collection form, page one. Review of same form, page one, 9b. identified pneumovax although there was no date entered. Review of facility Pneumonia Vaccine Informed Consent Form undated, included, "I have received the vaccine in the past. We would like to update our records. Do you remember when? Date received: about 2 years ago verbally per POA [power of attorney]." Although the form included education about pneumovax 23 vaccine and included risk and benefits, the form failed to identify if R106 wanted the vaccine. The current immunization record provided on 1/18/17, failed to identify date of pneumococcal vaccine, failed to identify type of pneumococcal vaccine, and failed to indicate if R106 wanted the pneumovax 23 vaccine administered.<br><br>R108, 85 years old, was admitted to the facility 1/16/17, according to facility Nursing Admission | {F 334} | A review was done for any other resident in the facility who has not had the vaccination offered and/or administered and corrections were made accordingly.<br>Nurses have been trained on the new, updated policy written from the CDC policy on the pneumococcal vaccinations, particularly about offering the vaccinations and administration<br>Under a new program designed to ensure that residents receive the new conjugate pneumococcal vaccinations  or at least the right to accept or refuse  a running list of residents will be kept by the DON and the infection control nurse. This list will also consist of a column to be checked-off when the vaccinations have been offered, rejected, or accepted, the date, name of person administering, as well as name of the vaccination. This list will be reviewed weekly by the infection control nurse and the DON together to verify that the new policy is being kept.<br>The facility ED will audit this list weekly x 4 and then monthly thereafter to ensure compliance with the policy and that the list is being kept up to date. The ED will report quarterly to the QA Committee on this program. | |

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| {F 334} | Continued From page 11 | {F 334} | | |

Continued From page 11

Admitting Nurse Part 1/Day 1 Version 1.4, Data Collection form, page one. Review of same form, page one, 9b. identified pneumovax although there was no date entered. Review of facility Pneumonia Vaccine Informed Consent Form undated, included: "I have received the vaccine in the past. We would like to update our records. Do you remember when? Date received: Rec'd @ Mayo-forgets." Although the form included education about pneumovax 23 vaccine and included risk and benefits, the form failed to identify if R108 wanted the vaccine. The current immunization record provided on 1/18/17, failed to identify date of pneumococcal vaccine, failed to identify type of pneumococcal vaccine, and failed to indicate if R108 wanted the pneumovax 23 vaccine administered.

Document review of facility Administering Pneumococcal Vaccines (PCV13 and PPSV23) to Adults, Including Geriatric Residents policy undated. Procedure for Vaccination included: assess adults for need of vaccination of PCV13 and PPSV23, screen for contraindications and precautions, provide vaccine information statements, prepare to administer vaccines, document vaccination, prepare to manage medical emergencies, report all adverse events to federal vaccine adverse event reporting system.

During interview on 1/18/17, at 2:06 p.m., director of staff development verified R106 and R108, pneumococcal vaccine forms were undated, did not identify type of vaccine and did not identify dates of the vaccine.

During interview on 1/19/17, at 10:10 a.m., Designated Infection Control nurse-A verified

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245304 | A. BUILDING ______<br>B. WING ______ | R<br>01/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET**<br>**CANNON FALLS, MN 55009** |

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|---|---|---|---|---|
| {F 334} | Continued From page 12<br>R106, and R108, lacked date of pneumococcal vaccine, type of pneumococcal vaccine, and failed to indicate if R106 and R108 wanted the pneumovax 23 vaccine administered. | {F 334} | | |
| {F 441}<br>SS=F | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; | {F 441} | | 2/15/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| {F 441} | Continued From page 13<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to implement a comprehensive infection control program which included consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all | {F 441} | Residents have been reviewed by the DON and Infection Control nurse to ensure that no negative effects have resulted from the deficient infection control program.<br>Nursing staff has been trained on the | |

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| {F 441} | Continued From page 14<br>61 residents, staff and visitors to the facility.<br><br>Findings include:<br><br>On 1/18/17, at 9:15 a.m., the infection control log for January 2017, was requested from the infection control nurse (ICN)-A. The ICN-A stated the December 2016 infection control log was not completed because she was off work for ten days due to an illness. The ICN-A provided a list of antibiotics that were prescribed for December 2016 and January 2017.<br><br>On 1/18/2017, at 3:05 p.m., the ICN-A provided a "Monthly Infection Control Log. The Monthly Infection Control Log from the 100 Wing (a transitional care unit) was dated from "12/16-1/17." The ICN-A stated she compiled the information today. The ICN-A was asked about the process used to compile and analyze data related to infections in the facility. The ICN-A indicated it is done at the end of each month vs. ongoing throughout the month to address infections timely to prevent the spread and educate the staff.<br><br>The Monthly Infection Control Log provided for Wing 100 (TCU) dated 12/16-1-17, revealed the following:<br><br>The "date of onset" of the infection form was missing for 11 residents listed.<br><br>The "organism(s)/date cultured" was missing for 14 residents listed.<br><br>The "date infection resolved" was missing for nine residents listed. | {F 441} | elements of the new infection control program and the infection control nurse has received assistance and training from the I-CAR program on developing and managing a successful infection control program. The DON will also receive this training.<br>Based on the I-CAR review and direction which will take place the week of 2/11/2017, a new infection control program has been developed which includes:<br>1. Consistent tracking of infections and treatment<br>2. Trending and analysis of illnesses and infections<br>3. Proper reporting to nursing so they are advised on the nature and treatment of infections in the facility.<br>4. Development of monthly infection control log<br>5. Tracking for organisms and antibiotic treatment<br>The DON will do an audit weekly x 4 and then monthly thereafter to ensure that the infection control nurse is properly developing and maintaining the infection control program including the tracking and trending logs. DON and Infection Control will meet weekly to review log sheets for completion and cross referencing of signs and symptoms of infections to ensure documentation is completed in the residents' records. Staff nurses will document residents' temperatures and signs and symptoms of infection upon noting symptoms and contacting the provider for clinical indicators and medication orders; with antibiotic | |

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| | 245304 | A. BUILDING ______ B. WING ______ | R 01/19/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET CANNON FALLS, MN 55009 |

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| {F 441} | Continued From page 15<br>The Monthly Infection Control Log requested for Wing 200 and Wing 300 was requested and not provided by the ICN-A.<br><br>The ICN-A was interviewed on 1/19/17, at 1:27 p.m. indicated a list of residents who had antibiotics prescribed for the month was provided by the nurse manager on each wing. ICN-A stated the lists did not include all infections or antibiotics that were prescribed.<br><br>The ICN-A stated the infection logs are not completed until the end of the month because that is when the pharmacy provided a list of prescribed antibiotics that were used.<br><br>The ICN-A stated the facility did not track employee illnesses. The ICN-A stated she was not aware tracking employee infections was necessary. Also the ICN-A would not be aware of the possible need to confine a resident or wing related to an outbreak of resident illness or if monitoring would be needed if patterns of infections were identified.<br><br>The director of nursing was not available for interview during the PCR survey.<br><br>A request was made for the infection control policy but not received. | {F 441} | administration; and for 5 days after antibiotic completion. The Infection Control nurse or the DON will report quarterly to the QA Committee on this program. | |
| F 520 SS=F | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a | F 520 | | 2/15/17 |

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| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET CANNON FALLS, MN 55009 |

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| F 520 | Continued From page 16<br>minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the Quality Assurance and Assessment (QA&A) effectively sustained | F 520 | The facility has a QA Committee and administration has reviewed it to ensure that it meets the standards required of a | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET CANNON FALLS, MN 55009** |

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| F 520 | Continued From page 17<br>ongoing compliance related to repeat citations form past surveys in regards to pneumococcal immunization, range of motion services including updating care plans, infection control program and environmental concerns, which were identified during the post certification resurvey (PCR) exited 1/19/17. This had the potential to effect all 61 residents residing in the facility.<br>Findings include:<br>See F253 Housekeeping and Maintenance Services.<br>See F318 Increase/Prevent Decrease in Range of Motion<br>See F334 Influenza and Pneumococcal Immunizations<br>See F441 Infection Control, Prevent Spread<br>Interview on 1/19/17, at 2:19 p.m. with the administrator, verified the QA&A committee meets quarterly and includes department heads including the director of nursing and medical director. Administrator when asked if the QA&A committee discusses action plans to correct identified quality deficiencies responded, the committee at their last meeting held on 1/18/17, had not discussed the plan of correction or previously cited deficiencies. Administrator stated they had recently been focusing more on the quality indicators including food quality.<br>Policy for Quality Assurance was not obtained from facility. | F 520 | QA Committee including the appropriate members, time frames for meeting, and the business of the committee which is, among other things, to keep quality assurance at an approved level, especially with regard to the citations received and corrected in the preceding surveys.<br>Management staff has been re-trained on the importance of the QA Committee and on ensuring that it fulfills its role of correcting facility deficiencies and maintaining those corrections. The following will be presented at QA Meetings as part of facility action plans: Corrections of F253, F318, F334 and F441.<br>A list of citations and programs developed to correct them has been created for the QA Committee. Based on this list, the QA Committee will review each program quarterly in the QA Committee over the course of the 2017 year to ensure compliance with the POC on each program. Where any variations are found, it will be the responsibility of the QA Committee to steer those programs back on track through the responsible parties.<br>The chairperson for the QA Committee will check-off when each program has been discussed and whether it has been approved as working properly during that quarter or if follow-up is needed.<br>The Facility ED will ensure that the QA Committee Program Checklist is completed and a copy delivered to each facility manager and member of the QA Committee within (7) days of the quarterly QA Committee. | |

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION A. Building B. Wing (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 245304 | | 1/19/2017 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET<br>CANNON FALLS, MN 55009 |

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).

| ITEM (Y4) ID Prefix | Reg. # | LSC | DATE (Y5) Correction Completed |
|---|---|---|---|
| F0166 | 483.10(j)(2)-(4) | | 01/10/2017 |
| F0241 | 483.10(a)(1) | | 01/10/2017 |
| F0242 | 483.10(f)(1)-(3) | | 01/10/2017 |
| F0243 | 483.10(f)(5)(i)-(iii)(6)(7) | | 01/10/2017 |
| F0278 | 483.20(g)-(j) | | 01/10/2017 |
| F0279 | 483.20(d);483.21(b)(1) | | 01/10/2017 |
| F0282 | 483.21(b)(3)(ii) | | 01/10/2017 |
| F0285 | 483.20(e)(k)(1)-(4) | | 01/10/2017 |
| F0309 | 483.24, 483.25(k)(l) | | 01/10/2017 |
| F0312 | 483.24(a)(2) | | 01/10/2017 |
| F0412 | 483.55(b)(1)(2)(5) | | 01/10/2017 |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| | GPN/kfd | 1/27/2017 | 37476 | 1/19/2017 |
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |
| | | | | |

FOLLOWUP TO SURVEY COMPLETED ON
12/1/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1) | MULTIPLE CONSTRUCTION (Y2) | DATE OF REVISIT (Y3) |
|---|---|---|
| 245304 | A. Building 01 - MAIN BUILDING 01<br>B. Wing | 1/10/2017 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET<br>CANNON FALLS, MN 55009 |

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| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0351 | Correction Completed<br>12/27/2016 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0363 | Correction Completed<br>12/27/2016 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0372 | Correction Completed<br>12/27/2016 |
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0374 | Correction Completed<br>12/27/2016 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0920 | Correction Completed<br>12/27/2016 | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) TL/kfd | DATE 1/27/2017 | SIGNATURE OF SURVEYOR 37008 | DATE 1/10/2017 |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 11/29/2016 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1678

February 2, 2017

Ms. Phyllis Malenke, Director of Nursing
The Gardens At Cannon Falls
300 North Dow Street
Cannon Falls, MN 55009

Subject: The Gardens At Cannon Falls - IDR
Provider # 245304
Project # S5304036, # H5304026

Dear Ms. Malenke:

This is in response to the letter received December 29, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F243 and F309 issued pursuant to the survey event 2C8411, completed on December 1, 2016.

The information presented with your letter, the CMS 2567 dated December 1, 2016 and corresponding Plan of Correction, as well as survey documents, face to face IDR review with Dr. Jay Hines, Vice President of Clinical Services for Superior Health Care, Phyllis Malenke, Director of Nursing at the Gardens at Cannon Falls, Thomas Paul, Executive Director of the Gardens at Cannon Falls at the time of the meeting, and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

## Tag F243, S/S – (E) 42 CFR § 483.10(f)(5)(i)-(iii)(6)(7) RIGHT TO [PARTICIPATE IN RESIDENT/FAMILY GROUP.

### Summary of the facility's reason for IDR of this tag:

The facility disputed the findings indicating staff have always respected residents' rights to have resident council meetings privately, indicating facility staff attend only upon invitation. The provider acknowledged the Recreational Therapy Director facilitates the resident council meetings and takes notes, but states this is done as requested by the council. The provider further stated the Recreational Therapy Director will continue to honor the overall Resident Council group's decision to have her participate, unless the group as a whole would request otherwise.

### Summary of findings.

The facility's CMS 2567 Statement of Deficiencies was reviewed in conjunction with the resident council minutes submitted by the facility. In addition, follow up discussion was held with MDH survey staff. As a result of this additional review, it was determined there was not sufficient evidence of a

deficient practice.

F243 will be removed from the Statement of Deficiencies.

## F309-S/S (G) 42 CFR §483.24, 483.25 (k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING.

### Summary of the facility's reason for IDR of this tag:
The facility asserts this finding is inaccurate, and disputes the findings as presented. The facility indicates R42's pain level was a six out of ten (10 being the most severe pain) on 11/14/16 and 11/15/16. They further stated R42's pain was a five out of ten on 11/16/16. Although the facility did not dispute the resident experienced chronic pain based on a medical condition, they questioned how R42 could recall what the pain level was 11 days later. In addition, the facility stated during the month of November 2016, R42's average pain level was 7.75 even when administered oxycodone, and was less when given Acetaminophen. The facility does not feel harm was caused during the 3 days identified in the 2567 when no oxycodone was available.

### Summary of findings:
R42's pain interview assessment dated 9/23/16, indicated R42 experienced pain almost constantly which was moderate in intensity. The pain assessment indicated R42 rated the constant pain as a 4 out of 10, and that R42 had indicated 4 out of 10 was tolerable.

Review of the narcotic log sheets identified R42 ran out of oxycodone at 1:46 p.m. on 11/13/16, and a new supply of the oxycodone was not received until 11/17/16.

Documents submitted by the facility including the Medication Administration Record (MAR), were reviewed for November of 2016. The MAR indicated that Acetaminophen 1000 mg (milligrams) had been administered at the following times: 11/13/16 at 4:45 a.m., for a pain level of 6; on 11/14/16 at 2:30 p.m., for a pain level of 6; on 11/15/16 at 1:26 a.m., for a pain level of 5; on 11/16/16 at 4:30 a.m., for a pain level of 5; and on 11/17/16 at 5:43 a.m., for a pain level of 10. Although R42's tolerable pain level had been assessed to be a 4, documentation in the MAR indicated the use of Acetaminophen 1000 mg was effective all days, except for Thursday 11/17/16 at 5:43 a.m., when R42's pain level was identified at a 10.

The November 2016 MAR further identified R42 had been administered oxycodone 6 times before running out of the medication on 11/13/16. According to the MAR documentation, when the oxycodone was administered, R42's pain level ranged from 7 to 9, averaging a pain level of 8. When R46 had received the last dose of oxycodone on 11/13/16 at 1:46 p.m., the pain level was documented as an 8.

On 11/17/16, documentation indicated R42 had requested Acetaminophen 1000 mg at 5:43 a.m., for a pain level of 10. The documentation in the MAR indicated the Acetaminophen was not effective. Facility records indicated the oxycodone arrived at the facility at 8:08 p.m. on 11/17/16, at which time it was administered to R42 for a pain level of 6.

Without the appropriate medication being available, the facility was unable to manage R42's pain at a

4 or less which R42 had indicated would be tolerable. R42 experienced actual harm, pain as a result.

The deficiency remains valid at a S/S of G.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-3793

cc: Dr. Jay Hines, Vice President of Clinical services for Superior Health Care
Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Gary Nederhoff, Rochester District Office Unit Supervisor

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245304 | A. BUILDING ______ B. WING ______ | 12/01/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET CANNON FALLS, MN 55009 |

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| F 000 | INITIAL COMMENTS<br><br>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.<br><br>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.<br><br>"A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey."<br><br>An investigation of complaints H5304036 were completed. This complaint was substantiated at F309.<br><br>An investigation of complaint H5304034 was completed during the survey and found not to be substantiated.<br><br>An investigation of complaint H5304033 was completed during the survey and found not to be substantiated. | F 000 | | |
| F 166 SS=D | 483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. | F 166 | | 1/10/17 |

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

Electronically Signed — 12/27/2016

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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| | 245304 | A. BUILDING ______ B. WING ______ | 12/01/2016 |

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| F 166 | Continued From page 1<br><br>(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br><br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br><br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing | F 166 | | |

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| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET CANNON FALLS, MN 55009** |

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| F 166 | Continued From page 2<br>written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br><br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br><br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br><br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br><br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br><br>(vii) Maintaining evidence demonstrating the | F 166 | | |

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| F 166 | Continued From page 3<br>result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure follow-up investigation into a complaint grievance in regards to missing electric razor for 1 of 2 residents (R34) reviewed for missing personal property.<br><br>Findings include:<br><br>R34's quarterly Minimum Data Set, dated 11/1/16 identified a Brief Interview for Mental Status score of 13 (cognitively intact).<br><br>During interview on 11/28/16, at 5:25 p.m. R34 stated he had been missing his electric razor for about two weeks, and was not sure if staff were looking for it. Although he had reported it to a nursing assistant staff, no one had gotten back to him.<br><br>During interview on 11/29/16, at 3:15 p.m. the social worker (SW)-A stated there should be a form filled out on any missing resident items. SW-A further stated that nursing assistants should fill them out if they are told a resident has lost something and it is not located. SW-A then provided the missing item reports for the previous nine month period at this time, consisting of only two reports. Neither of the reports were for R34's razor.<br><br>During interview on 11/30/16, at 11:18 a.m. registered nurse (RN)-B stated she was unaware R34 was missing a razor. Any staff member who was aware an item was missing should fill out a | F 166 | R34's family has been notified, and are purchasing a new razor for the resident. The facility has drafted a new policy and procedure on the filing of grievances and will present it to all residents and families upon admission. It will be presented at the next resident council meeting. The residents' families will be mailed copies of the new resident grievance and lost items forms. These forms are also now included in the admissions packets. All grievances will be tracked and monitored weekly. Families and residents will be notified of findings.<br>This will be monitored by the Director of Social Service and will be completed by 1-1-2017 | |

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| F 166 | Continued From page 4 complaint form for the missing item and turn it in to social services. RN-B stated R34 was shaved for Veteran's Day and would likely have had it then.<br><br>During interview on 11/30/16, at 11:20 a.m. licensed practical nurse (LPN)-A stated she was aware activities had given R34 a razor a while ago and now it was missing, but could not state the date she had been informed it was gone.<br><br>During interview on 11/30/16, at 11:31 a.m. the activities director (AD) stated R34 was missing a brand new razor he had gotten and that it had happened within the last month. The AD stated she had wanted to purchase R34 a new one, however did not have the funds in her budget the last time she went on a shopping trip. The AD stated it was on her list to purchase at a future date. The AD was not aware of any missing item reports filled out for the razor.<br><br>The facility policy entitled Lost and Found, undated, stated resident or family complaints of missing items must be reported to the Director of Nursing Services, and reports of misappropriation or mistreatment of resident property are immediately investigated. | F 166 | | |
| F 241 SS=D | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced | F 241 | | 1/10/17 |

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| F 241 | Continued From page 5<br>by:<br>Based on observation, interview and document review, the facility failed to ensure a dignified environment for 1 of 1 resident (R42) reviewed for dignity whose urinary incontinence supplies and catheter bag were left exposed and uncovered in her room.<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified diagnoses of paraplegia and urinary retention.<br><br>R42's annual Minimum Data Set, dated 9/23/16 identified a Brief Interview for Mental Status score of 15 (cognitively intact).<br><br>During interview on 11/28/16, at 5:43 p.m. R42 stated she was not always treated with respect and dignity. R42 indicated she did not like her catheter bag being left uncovered and her incontinence products being left out for anyone entering the room to see. R42's catheter bag was visualized at this time to be hanging on the end of her bed, uncovered with urine present in the bag. A box of gloves and incontinence wipes was sitting on top of her bedside stand. R42 further stated she rarely got out of bed due to having a pressure ulcer on her bottom that required frequent repositioning.<br><br>During observation on 11/30/16, at 3:51 p.m. R42's catheter bag was uncovered with urine draining into the bag and an incontinence pad was lying out on her bedside stand.<br><br>During observation on 12/1/16, at 10:13 a.m. R42 was assisted with morning cares. Nursing assistant (NA)-A and NA-B proceeded to assist | F 241 | Per resident request, Resident R42 has met with Social Worker, Nurse Manager, Ombudsman and DON to review care plan on 12/28/2016.<br>The admission nurse will put order in PCC upon admission for patients with catheters to ensure catheter bag is covered every shift and all residents /patients with catheters will have order added to PCC order portal on 12/21/2016.<br>An audit will be developed and will be performed weekly by evening Nurse Manager to ensure that incontinence products, gloves, etc. are out of view of visitors/other residents and all catheter bags are covered when cares are not being performed. Staff meeting minutes on 1/4/2017 will include reviewing resident dignity policy.<br>This will be monitored by the Nurse Managers and DON | |

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| F 241 | Continued From page 6<br>R42 with washing the top half of her body, then applying a clean gown and washing her lower half and providing incontinence care. At 10:37 a.m., Licensed practical nurse (LPN)-A proceeded to complete wound care on R42's pressure ulcer. At 10:54 a.m., R42's morning cares were completed and all staff exited R42's room. An incontinence pad was lying on R42's bedside stand along with some gloves, and her urinary catheter was exposed without a cover on it, hanging at the end of her bed. Dark amber urine was present in the bag.<br><br>During interview on 12/01/16, at 11:13 a.m. R42 stated it bothered her that the catheter bag was left out and incontinence supplies were on her bedside stand, as she was unable to pick them up herself. R42 stated anyone who stopped by her room would be able to see them and know she had bowel and bladder issues, and she did not feel she should have to remind staff to pick them up.<br><br>During interview on 12/1/16, at 11:24 registered nurse (RN)-B stated she would have expected R42's catheter bag be covered whenever she was out of the room, but not necessarily in bed. RN-B confirmed that incontinence products being left out was undignified.<br><br>During interview on 2/1/16, at 11:23 a.m. the director of nursing (DON) stated that incontinence products should not be left out in resident rooms, but stated as long as a urinary catheter bag didn't face the hallway it might be okay.<br><br>A facility policy was requested related to activities of daily living and provision of dignified services, none was provided. | F 241 | | |

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| F 242 SS=D | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 2 of 3 residents (R42 & R11) reviewed for choices received baths according to their preferences for bathing frequency.<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified a diagnoses of paraplegia and urinary retention.<br><br>R42's annual Minimum Data Set (MDS), dated 9/23/16 indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact).<br><br>R42's care area assessment (CAA) for activities of daily living (ADL), printed 12/1/16 indicated R42 was totally dependent upon staff in all ADL and was alert and oriented. Proceed to care plan to maintain current level of functioning. | F 242 | Admission assessment updated to include questions of preference of bath/shower, time (day/evening) for weekly bath /shower. Extra weekly bath/showers can be accommodated based on staff scheduling. Review of bath/shower schedule by DON/Nurse Managers monthly to ensure consistency of bath schedule on Kardex and in care plan.<br><br>Nurse meeting agenda on 1/4/2017 included education of documenting bath/shower body audit and refusals. Nurse Manager to conduct weekly audits on Refusal to ensure body audits are completed and documentation of baths given and or refused. Bath audit assessment updated to include nurse documentation of bath/shower given or | 1/10/17 |

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| F 242 | Continued From page 8 | F 242 | refused. | |

R42's care plan, dated 12/1/16 indicated R42 required assistance of two staff for bathing and should receive a bed bath weekly and as needed (PRN).

R42's nursing admission assessment, dated 3/9/16 did not identify how often R42 preferred a bath.

During interview on 11/28/16, at 5:42 p.m. R42 stated she was not bathed according to her preferences and had not been asked how often she would like a bath, and receiving extra baths was "not encouraged." R42 stated she was trying to use dry shampoo on her hair and did not always even get her hair brushed on a daily basis.

During follow up interview on 12/1/16, at 10:12 a.m. R42 stated she would like a bath a couple of times per week if possible, however she was aware it took a lot of time for the staff. R42 stated she thought she was told this would be an extra charge at one point during her stay.

During interview on 12/1/16, at approximately 2:30 p.m. the social worker (SW)-A indicated all residents were asked about bathing frequency on their admission nursing assessment, any documentation of such should be included on this form.
R11 had been interview on 11/30/16, at 11:38 a.m. the resident indicated she had not had a bath for the past 2 weeks. R11 included she thought the staff were too busy to give her a bath during these times. R11 further included she would like a bath at least weekly.

Review of the current quarterly Minimum Data

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| F 242 | Continued From page 9 | F 242 | | |

Set (MDS) dated 10/28/16, indicated R11's bathing did not occur during this assessment period. R11 receives 1 assistance with bathing. The resident's brief interview for mental status BIMS score was 15 out of 15 (meaning cognition is intact).

Review of the most current plan of care for R11, identifies the resident as having an activities of daily living self -care deficit related to being easily fatigued, strength decrease, history of falls, muscle weakness and atrophy. Interventions; requires 2 assistance with bathing, washing and transfers. Staff to wash hair and do nail care.

Review of the weekly bathing sheets for the past month, indicated R11 received a bath on 10/30/16, 11/5/16 and 11/12/16, but did not include bathing for the weeks of 11/19/16 or 11/26/16.

Interview with the facility MDS coordinator on 11/30/16, at 11:41 a.m. confirmed R11 did not receive a bath during the MDS quarterly assessment period dated 10/28/16. The MDS coordinator also included that she had not not investigate as to why the resident did not receive a bath during this time.

Interview with registered nurse (RN)-B a nurse manager on 11/30/16, at 1:35 a.m. confirmed there was no documentation that R11 had received a bath in the past 2 weeks. She also confirmed R11's skin checks during bathing had not been completed as well.

Interview with nursing assistants (NA)-C, NA-D and NA-E on 11/30/16, at 1:43 p.m. indicated they were primary caregivers for R11's wing and

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| F 242 | Continued From page 10<br>confirmed the resident receives a weekly bath on Saturdays, but could not verify a bath had been given.<br><br>A policy regarding bathing was requested, none was provided. | F 242 | | |
| F 253<br>SS=E | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to maintain a clean, sanitary environment, and resident rooms in good repair, for residents, staff and visitors. This had the potential to affect 12 residents on the two hundred wing.<br><br>Findings include:<br><br>Observations noted during the initial tour on 11/28/16, and verified on 12/1/16, at 12:50 p.m. with the environmental director (ED) were as follows:<br><br>During the initial tour on 11/28/16 at 2:48 p.m., a strong pungent odor was present in the hallway located at the nurses station on the 200 wing.<br><br>On 11/30/16 at 2:48 p.m. R42 complained to the surveyor "the carpet smells of pee, and becomes unbearable, especially in the summer, they know about it [in regards to telling staff of the smell]."<br><br>The strong pungent odor of urine in the hall by the | F 253 | Carpet odor in 200 wing: Entire length of the hall was cleaned and disinfected. Housekeeping and Maintenance will monitor on a daily basis and clean areas that are soiled or have odors of urine. Nursing will monitor the residents on the 200 wing who are known for having incontinence problems and are mobile in the hallways and change residents who may have soiled clothing. Rooms are cleaned daily and those rooms with odors issues will be checked more than daily to ensure odors are maintained at an acceptable level.<br>R13 wheelchair and R35 wheelchair were cleaned. A policy and procedure for cleaning wheelchairs will be developed and implemented. The policy will require the nursing staff to notify the housekeeping staff when a wheelchair is in need of cleaning. Nursing will label the wheelchair with the resident's name and take it to the housekeeping department where it will be cleaned and then returned | 1/10/17 |

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| F 253 | Continued From page 11<br>nurses station, and also outside of rooms on the 200 wing, was noted during the survey on 11/28/16 at 2:48 p.m., 11/30/16 at 10:47 a.m., 11/30/16 at 2:48 p.m., and 12/1/16 at 10:15 a.m.<br><br>On 11/30/16 10:47 a.m. an observation revealed that the carpet was soiled heavily with debris the length of the 200 hallway with multiple stains, also the door strips to the rooms had grime, dirt and debris. Hallway carpet located outside R23 had a large white stain. Food debris was observed to be located directly outside of R4's room.<br><br>R13's wheelchair was observed to be soiled, a substance that appeared to be nuts was built up in the foot pedals, brown debris was visible and the chair upholstery felt sticky to the touch.<br><br>R35's wheelchair was observed to be soiled with debris, the foot plate of the chair was soiled with dried on food and debris.<br><br>R81 was interviewed on 11/29/16 at 10:51 a.m., and stated, "I feel that my room is filthy." R81's bedroom floor was observed to have dry and wet puddles of a brown amber liquid. The floor revealed surface damage, the appearance in the wax surface was uneven. In R81's bathroom the faucet was leaking and the sink had stained rusty orange across the bowl. The tile is stained brownish red all along the outside edges extending 6-8 inches into the center of the floor. R81 stated, "It is easy to see that the stool needs a new seal, I don't know why they don't just fix it." The bathroom also had a strong malodorous smell which was concentrated by the entryway to the room.<br><br>On 11/30/16 at 2:21 p.m., the housekeeper | F 253 | to the nursing department. Nursing will monitor this daily.<br>R81 sink and stool were cleaned and new gaskets have been installed. Floor was cleaned. All bathrooms are cleaned on a daily basis and housekeeping will notify maintenance of repairs which need to be conducted to ensure that broken items are repaired and missing items are replaced. Monitored by housekeeping and maintenance daily.<br>R34 privacy curtain was replaced, walls were patched, sanded and painted. Nursing, housekeeping and maintenance staff will check rooms daily and on a random basis for torn or soiled curtains and privacy curtains. When a room is vacant, housekeeping does a deep cleaning and replaces the privacy curtains.<br>R4 walls were patched, sanded and painted and ceiling tile was replaced. Maintenance and housekeeping will monitor rooms during cleaning on a daily basis and note areas that need repair and inform maintenance by writing needed repairs in the maintenance log on each nursing station.<br>R35 ceiling tile was replaced. Housekeeping, maintenance and nursing will monitor for ceiling tile repairs and note in the maintenance log on each nursing unit to notify maintenance of needed repairs.<br>R15 blinds were replaced. Maintenance and housekeeping will monitor rooms when they are being cleaned on a daily basis for items that need to be repaired or replaced and will note items on the | |

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|---|---|---|---|
| | 245304 | A. BUILDING ______ B. WING ______ | 12/01/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET CANNON FALLS, MN 55009 |

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| F 253 | Continued From page 12<br>(HC)-A was interviewed. She stated that she has mopped the room today, and that the floor recently had a deep cleaning. She confirmed that there is a strong urine odor.<br><br>On 11/30/16 at 2:30 p.m. R34 privacy curtain is soiled and stained with a reddish brown color substance 4 feet off of the floor. The walls were heavily scraped with missing paint and surface damage behind the chair and the bed.<br><br>On 11/29/16 at 11:16 a.m. during a interview with R4, the ceiling tile is observed to be discolored, and bowing away from the strip where the heat register is located. The walls in the bathroom have patches of plaster, they are not painted. There is a 2 inch piece of ceiling tile missing.<br><br>On 11/28/16 at 6:13 p.m. during the initial interview with R35, cracked ceiling tile is observed in the bathroom.<br><br>During a interview with R15 on 11/28/16 at 6:49 p.m. 5 inch strips of blinds are observed to be missing from the window.<br><br>On 11/28/16 at 4:44 p.m. during a interview with R 72, the bathroom towel holder is missing, the wall is damaged, where it was hanging. R72 states that he notified the staff 6 weeks ago.<br><br>On 11/28/16 at 4:44 p.m. R13 wheelchair had been found to be soiled with debris. The foot pedals have ground in brown food debris, the seams of the wheelchair had a layer of dried food debris.<br><br>On 12/1/16 at 12:30 p.m. Wall paper in the hallway between room 217-219, and | F 253 | maintenance logs on each nurses station to notify maintenance of needed repairs or replacements.<br>Wall paper in the 200 wing hallway was patched and repaired where the wall board was exposed. All building hallways and rooms where wallpaper is on the surface will be monitored by housekeeping and and maintenance on a daily basis as they work throughout the building. Existing damage to walls will be patched and painted.<br>Monitored by Maintenance, Housekeeping and Administration | |

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| F 253 | Continued From page 13<br>rooms 201-230 had multiple torn/scraped off in multiple areas revealing the wallboard below.<br><br>On 12/1/16 at 12:30 p.m. in the dining room there was a 5 inch x 16 foot long black mark along the wall, ceiling tiles were noted to have pieces missing. There is a 18 inch by 4 foot area where the wall is damaged. The wall paper was missing through out revealing a damaged wall board below. There was a thick layer of plaster applied but had not been smoothed nor painted.<br><br>During the tour on 12/1/16 at 1:30 p.m., the ED verified the housekeeping staff cleaned each room and bathroom daily. He confirmed that the carpet should be replaced and that it was discussed in a meeting, but not budget approved. The ED stated the housekeepers and nursing staff were responsible to report when repairs were needed. When in the 200 wing the ED presented a clip board that was used for communication, when there were environmental issues in need of repair. There were no notes on the communication board.<br><br>A policy for building maintenance was requested on 12/1/16 at 2:00 p.m. The ED presented a paper titled maintenance repair list. He was unaware of a policy for maintenance. | F 253 | | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate | F 278 | | 1/10/17 |

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| F 278 | Continued From page 14 | F 278 | | |

participation of health professionals.

(i) Certification
(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1 resident (R45) reviewed for oral/ nutritional needs.

Findings include:

R45's Minimum Data Set (MDS) 5 day assessment dated 10/14/16, identified the

**Provider's plan of correction:**

A modification of the 14 day MD for R45 was submitted the day it was noted by the survey team. The MDS Coordinator will review and check all the section of the MDS For accuracy of other departments entries and confirm the information with the care plan with each MDS (at least quarterly).
Completion date 1-10-2017
Monitored by the MDS Coordinator

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| F 278 | Continued From page 15<br>resident as having a mechanically altered diet. R45's MDS 14 day assessment dated 10/19/16, identified the resident as having tube feedings and mechanically altered diet.<br><br>During an observation on 11/29/16, at 8:59 a.m. R45 was observed to be feeding herself independently hot oatmeal cereal and had a breakfast tray with other regular foods and liquids located on the tray.<br><br>When interviewed on 11/30/16, at 2:00 p.m. the dietary manager (DM) verified R45 never had a feeding tube and confirmed it was an inaccurate coding on the MDS dated 10/19/16. | F 278 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive | F 279 | | 1/10/17 |

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| F 279 | Continued From page 16<br>care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by: | F 279 | | |

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

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| F 279 | Continued From page 17<br>Based on interview and document review, the facility failed to develop a comprehensive plan of care for 1 of 2 residents (R72) who had a history of substance abuse and possession of illegal drugs.<br><br>Findings include:<br><br>R72's progress notes dated 10/3/16, indicated R72 had a canister of marijuana in his room. The note indicated the resident attempted to hide the canister when he found out the staff called the police, due to his possession of an illegal substance in the facility. The progress note further indicated the police confirmed the canister contained the illegal substance of marijuana. Review of the progress notes dated 11/8/16, indicated R72 was observed to have a marijuana pipe in his room, while the police were at the facility investigating a complaint. The note further included the police tested the pipe and it was confirmed for marijuana.<br><br>Review of R72's diagnosis list obtained from the admission diagnosis sheet included; alcohol abuse with intoxication, psychoactive substance abuse, major depressive disorder, adjustment disorder with anxiety and personality disorder.<br><br>Review of R72's admission Minimum Data Set (MDS) dated 8/18/16, indicated the resident had diagnosis that included psychoactive substance abuse along with alcohol abuse.<br><br>Review of R72's current plan of care did not include the residents history of drug abuse nor did it include monitoring for possession of illegal substances. | F 279 | Care plan for R72 has been reviewed and updated to include focus, goals and interventions with history of and potential current use of illegal substances. Nursing order added to PCC for nurse to observe for sign of substance abuse and possession which include notifying local authorities if illegal substances are identified, which will protect other residents. Newly discovered issues will be added to the individualized plan of care by the appropriate department as they are discovered. Nurse manager to review resident's chart weekly or more frequently for notes regarding illicit substance abuse and/or presence.<br>Completion date 2-1-2017<br>Monitored by Nurse Managers, DON and MDS Nurse | |

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| F 279 | Continued From page 18<br>Interview with the director of nursing (DON) on 12/2/16, at 1:00 p.m. confirmed the plan of care did not include monitoring for R72's history or possession of illegal substances. | F 279 | | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R42) reviewed for activities of daily living was provided assistance with oral hygiene and grooming in accordance with the care plan.<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified a diagnosis of paraplegia.<br><br>R42's annual Minimum Data Set (MDS), dated 9/23/16 indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The MDS also identified R42 required extensive assistance of two staff for grooming activities.<br><br>R42's care area assessment (CAA) for activities of daily living (ADLs), printed 12/1/16 indicated R42 was totally dependent upon staff in all ADLs and was alert and oriented. Proceed to care plan | F 282 | R42's care plan updated to reflect that resident is able to dictate personal cares and will be encouraged to perform her own cares and when unable to request that staff assist her.<br><br>Resident R42 has been included in the new resident dignity grooming program. Residents have had their care plans reviewed and grooming and ADL corrections were made as necessary. Nursing will be inserviced by 1/10/17 on proper care planning to address ADLs and the new resident dignity grooming program.<br>A new care planning program has been put into place that includes a strong focus on grooming and ADLs. A new resident dignity grooming checklist has been developed. This checklist will be used on a daily basis to evaluate and ensure that | 1/10/17 |

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| F 282 | Continued From page 19<br>to maintain current level of functioning.<br><br>R42's care plan, dated 12/1/16 indicated R42 required assistance of one staff member to set up supplies and assist her for oral care, and assistance of one staff in all other areas of hygiene. The care plan also indicated R42 was to get her hair washed one additional time weekly on her request, not a full bath, rather just a hair wash.<br><br>During interview on 11/28/16, at 5:42 p.m. R42 stated she was trying to use dry shampoo on her hair and did not always even get her hair brushed on a daily basis.<br><br>During observation of morning cares on 12/1/16, at 10:13 a.m. nursing assistant (NA)-A and NA-B washed their hands and applied gloves, uncovered R42's upper half and proceeded to cleanse R42's skin folds and underarms and apply powder beneath the folds. NA-A and NA-B uncovered R42's lower half of her body, cleaning underneath the skin folds of the abdomen and perineal area, rolled R42 on her side and cleansed her perineal area. After removing their gloves and disposing of the soiled linens into a plastic bag, licensed practical nurse (LPN)-A proceeded to provide wound care to R42's pressure ulcer, removing the soiled wound dressing materials, irrigating the wound with an antibacterial solution, cleansing her hands and proceeding to pack the wound with new dressing change materials. When completed, LPN-A removed the soiled dressing materials. NA-A and NA-B proceeded to roll R42 onto her side and set a magnetic wound therapy device underneath R 42 and cover her up with her bed linen. LPN-A turned the magnetic device on and exited the | F 282 | residents are receiving proper grooming and ADL care according to care plan. Unit managers will audit 10% of residents weekly x 4 weeks and then monthly thereafter to ensure that the new resident dignity grooming checklist is being properly used. All completed checklists will be delivered to the DON for review by her or her designee.<br>The DON or her designee will report to the QA committee monthly. | |

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| F 282 | Continued From page 20<br>room. NA-A and NA-B proceeded to remove their gloves and wash their hands, and exited the room without offering R42 her oral care materials nor offering to brush her hair or giving her the brush.<br><br>During interview on 12/1/16, at 11:13 a.m. R42 stated she would have liked to brush her hair and teeth after morning cares, "That would be kind of normal, wouldn't it?"<br><br>During interview on 12/1/16, at 11:24 a.m. registered nurse (RN)-B stated she would have expected staff to offer R42 her grooming materials to brush her hair as well as her oral care supplies with morning cares.<br><br>A policy related to activities of daily living and grooming was requested, none was provided. | F 282 | | |
| F 285 SS=D | 483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR<br><br>(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a | F 285 | | 1/10/17 |

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| F 285 | Continued From page 21 | F 285 | | |

significant change in status assessment.

(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

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Continued From page 22

(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET<br>CANNON FALLS, MN 55009 |

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| F 285 | Continued From page 23<br>described in 435.1010 of this chapter.<br><br>(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 2 of 4 residents (R56, R81) reviewed for preadmission screening who had history of serious mental illness (MI) had a Level II preadmission screening and resident review (PASRR) on file.<br><br>Findings include:<br><br>R56's face sheet, dated 11/30/16 indicated primary diagnoses of schizophrenia and major depressive disorder.<br><br>An initial pre-admission screening from the Senior Linkage Line, dated 10/12/16 indicated a primary diagnosis of schizophrenia and a history of mental illness.<br><br>A social services progress note, dated 10/13/16 indicated staff were waiting on Olmsted County related to the Level II PASRR screen. No follow-up phone calls or additional documentation was charted or provided to surveyor.<br><br>During interview on 11/28/16, at 7:02 p.m. R56 stated he routinely saw a psychiatrist for mental health issues and had been in an inpatient treatment facility for approximately ten years. | F 285 | Social Worker has notified Goodhue County that Level II screenings are required for R56 and R81, and is awaiting completion and delivery of screenings. Call placed weekly to check on progress while awaiting screenings. Level I pre-admission screening will be reviewed or completed as needed by Admissions prior to admission. Admissions will report to Social Services if level II screening is indicated. Social Worker will notify the appropriate county to complete level II screening. Tracking log to be kept in Social Services office, monitoring to be completed by Social Worker with each MDS Assessment (at least quarterly).<br>Completion date 1-10-2017<br>Monitored by MDS and Social Services | |

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| F 285 | Continued From page 24 | F 285 | | |

During interview on 11/29/16, at 3:44 p.m. the social worker (SW)-A confirmed R56 met criteria for a Level II PASRR and had been admitted from another facility in 10/16. SW-A indicated she had called the county previously to check on the PASRR, but was unsure of the status and did not have one on file for R56.

On 11/30/16, at 9:10 a.m. a Level II PASRR form for R56 was faxed to SW-A from Goodhue County, indicating R56 had documented history of mental illness and did not need specialized services.

During interview on 11/30/16, at 9:14 a.m. R56's previous county case worker (CW)-A stated R56 did require mental health services which had been set up in his present county of residence and would not require any other specialized services. CW-A was not sure of the status of the PASRR assessment.

R81's face sheet, dated 12/01/2016, indicated primary diagnoses bipolar disorder and schizophrenia. The electronic medical record (EMR) included schizophrenia, dated 7/19/16, listed under the diagnosis tab.

An initial pre-admission screening from the Senior Linkage Line, dated 7/18/16, indicated a primary diagnosis of bipolar disorder. The box was checked for the following "The OBRA (Omnibus Budget Reconciliation Act [This is a federal program that requires the identification of individuals with serious Mental Illness (MI) or Developmental Disabilities (DD) indicators who are requesting admission to a nursing facility (NF) to determine the most appropriate care setting and services]) Level 1 Screening indicated a

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| F 285 | Continued From page 25<br>Level II Mental Health Evaluation and final review of the need for specialized services is required."<br><br>On 11/29/16, at 5:07 p.m., SW-A was interviewed regarding the lack of a Level II Pre-Admission Screening and Resident Review (PASRR) screening. The Senior Linkage Line document was reviewed with the SW-A. The SW-A stated the need for the Level II screening was missed and confirmed there was not one on file.<br><br>On 11/29/16, at 5:30 p.m. the administrator, director of nursing and admission coordinator were together in the administrator's office. When interviewed , they stated they were not aware of R81 lacked a Level II PASRR.<br><br>On 12/1/16, at 10:57 a.m. an unsigned Level II PASRR form, from Goodhue County, for R81 was faxed to the SW-A. The form indicated R81 had documented history of mental illness and did not need specialized services.<br><br>A policy related to PASRR assessments was requested, none was provided. | F 285 | | |
| F 309 SS=G | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care. | F 309 | | 12/27/16 |

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| F 309 | Continued From page 26<br>483.25<br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure narcotic pain medication to control chronic moderate to severe pain was available timely for 1 of 1 resident (R42) reviewed for pain control. R42 experienced actual harm when the facility was out of the narcotic medication supply for three days before the pharmacy provided the medication, during which time R42 experienced severe pain.<br><br>Findings include:<br><br>R42's face sheet dated 12/1/16, identified diagnoses of paraplegia, neuropathy and chronic pain syndrome.<br><br>R42's annual Minimum Data Set (MDS) dated 9/23/16, indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The MDS also indicated R42 received as needed pain medications and experienced moderate pain that interfered with daily activities. | F 309 | Resident #42 was seen by a physician for pain and a new program was put into place to ensure that pain medications are always available.<br>Under the direction of the DON, nursing conducted a review of all residents on pain medication to ensure appropriate availability and delivery of pain medications is taking place. Corrections were made as required.<br>Nurses will be in-serviced on 1-4-17 on ordering medications including narcotics and e-kit use to ensure that medications, including narcotics are properly ordered so they are always available for residents with orders for them. This training will include steps to be taken for various pain medication scenarios, including resident refusing pain medications on hand, increased narcotic usage and preventing a rapid depletion of any back-up narcotic. The evening nurse manager will audit narcotic supplies routinely on Mondays | |

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| F 309 | Continued From page 27<br>R42's Care Area Assessment (CAA) for pain indicated R42 had almost constant moderate pain that limited her day-to-day activity. The CAA indicated R42 was alert, oriented and able to request pain medications.<br><br>R42's care plan last revised 7/10/16, indicated R42 was at risk for impaired comfort with a goal of having discomfort less than daily. Interventions included administering medications as ordered for pain.<br><br>R42's physician's orders dated 12/1/16, identified orders for oxycodone (a short acting narcotic analgesic) 5 milligram (mg) tablets by mouth every four hours as needed (PRN) for pain related to chronic pain syndrome. The physician's orders also identified Fentanyl (a narcotic) pain patch 25 micrograms every 72 hours topically, as well as gabapentin (a medication used to treat nerve pain) 400 mg by mouth three times daily for chronic pain syndrome.<br><br>R42's pain interview assessment dated 9/23/16, indicated R42 experienced pain almost constantly which was moderate in intensity. The pain assessment indicated R42 rated the pain as a four out of ten (10 being the most severe pain), and indicated R42 indicated a 4 was tolerable.<br><br>R42's medication administration record (MAR) dated 11/16 indicated R42 had received oxycodone 5 mg tablets a total of 14 times during the month of November 2016 for pain levels ranging from a ten to a five on a ten-point scale. The November 2016 MAR indicated R42 had not received any oxycodone from 11/14/16 to 11/16/16. Documentation on the MAR indicated R42 had received as needed doses of | F 309 | and Thursdays to ensure that an adequate supply of narcotics is on hand and that all re-orders have current scripts on file at the pharmacy. Unit managers and the DON will be advised when the narcotic supply is low.<br>The Director of Nursing or her designee will audit back-up narcotic supplies for sufficiency weekly x 4 and then monthly thereafter. The DON or designee will report monthly to the QA Committee. | |

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acetaminophen 1000 mg on November 15, 16 and 17, 2016. R42's pain level listed for an acetaminophen dose given at 9:56 a.m. on 11/15/16, was identified as a 6. At 10:01 p.m., R42 had received another 1000 mg of acetaminophen for pain ranked at a 7. On 11/16/16, at 4:30 a.m. R42 rated her pain at a level 5 and received an additional 1000 mg of acetaminophen. At 5:43 a.m. on 11/17/16, R42 rated her discomfort at a ten. A nursing progress note dated 11/17/16 at 5:45 a.m., indicated R42 had been calling out and crying "Burning from nerves." The note further indicated the resident had orders for oxycodone however, the medication had run out and had been reordered from the pharmacy. The progress note indicated the resident continued to cry out and had been given PRN Tylenol 1000 mg at 5:45 a.m.

Even though R42 experienced discomfort and required as needed acetaminophen, documented follow up notes on the medication administration recored (MAR) indicated "E" (for effective) after each dose of acetaminophen R42 had received.

R42's narcotic log sheets for the months of October and November 2016 identified R49's prn oxycodone supply had run out at 1:45 p.m. on 11/13/16, and a new supply card was not checked in until four days later on 11/17/16, with the first dose administered from the card at 8:08 p.m. on 11/17/16.

During interview on 11/28/16, at 6:13 p.m. R42 stated she had experienced severe pain for three days when she did not have her oxycodone. R42 stated she thought they were out of the narcotic due to the doctor needed to send a new script to the pharmacy for the medication and then R42

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remembered this was taken care of in November 2016. R42 stated no one had offered her oxycodone from the facility's emergency narcotic supply. When asked how severe her pain level had gotten, R42 stated "Oh, my [expletive] it was a nine!" The nine was based on a 1 to 10 pain scale and 9 bing excrutiating. R42 said the oxycodone helped manage the nerve pain she experienced in her hands.

During a follow-up interview on 11/30/16, at 3:51 p.m. R42 clarified her pain had been an 11 (worse than excruciating) during the time period when she had not received the oxycodone (between 11/13 and 11/17/16).

The director of nursing (DON) was interviewed on 11/30/16 at 4:32 p.m., she stated she was aware R42 had run out of her oxycodone around 11/13/16, and confirmed she would have expected staff to call the doctor on call to be able to provide coverage from their emergency kit supply. The DON stated she was unsure about the facility's policy related to procuring emergency supplies of medication from the pharmacy. She stated registered nurse (RN)-B would be the best person to ask about this situation.

During interview with licensed practical nurse (LPN)-B on 12/1/16 at 8:05 a.m., LPN-B stated the procedure to get emergency narcotics from the pharmacy included calling the pharmacy and getting authorization to take a medication from the emergency kit. LPN-B indicated sometimes staff had difficulty procuring re-order supply of narcotics from the pharmacy when the pharmacy needed a new script.

During interview on 12/1/16, at 8:44 a.m. LPN-A

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stated she recalled R42 running out of oxycodone on 11/13/16. LPN-A stated she had pulled the medication label to re-order the medication a few days before it ran out. LPN-A also stated she had faxed the pharmacy for more supply which never came in due to the pharmacy requiring a renewed script for the medication. LPN-A stated staff did not realize for a while that the pharmacy required a new prescription. She said they had then faxed R42's physician for the new prescription and during the time R42 was waiting for her oxycodone, LPN-A recalled offering gabapentin and the acetaminophen which she said R42 had expressed was effective.

During interview on 12/1/16 at 10:09 a.m., RN-B confirmed R42 had run out of oxycodone for several days between 11/13/16 and 11/17/16. RN-B said the medication renewal was faxed to the pharmacy but never came, and that staff sometimes had trouble getting medication when the prescriptions ran out.

During interview on 12/1/16 at 12:51 p.m., the consultant pharmacist (CP) stated staff at the facility should have called the pharmacy or on-call physician to get an emergency supply of oxycodone when R42 was having pain, as it was available in their e-kit (emergency kit).

A facility policy, untitled and undated included: "the pharmacy shall provide any pharmacy product needed on an emergency basis as promptly as is reasonably practicable. In the event pharmacy cannot furnish a pharmacy product ordered on an emergency basis in a reasonably prompt manner, pharmacy shall use its best efforts to determine whether another pharmacy provider is capable of providing such

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| F 309 | Continued From page 31<br>pharmacy product to facility more promptly than pharmacy." | F 309 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure oral hygiene and grooming needs (hair combed) were provided for 1 of 3 residents (R42) reviewed who were dependent upon staff assistance with activities of daily living (ADL).<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified a diagnosis of paraplegia. R42's annual Minimum Data Set (MDS), dated 9/23/16 indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The MDS also identified R42 required extensive assistance of two staff for grooming activities.<br><br>R42's care area assessment (CAA) for activities of daily living (ADLs) printed 12/1/16, indicated R42 was totally dependent upon staff for all ADL's and was alert/oriented. Proceed to care plan to maintain current level of functioning.<br><br>R42's care plan dated 12/1/16, indicated R42 required assistance of one staff member to set up supplies and assist her for oral care and assistance of one staff in all other areas of | F 312 | Resident #42 has a new ADL program in place which includes oral care and grooming; this is being provided daily.<br>A new policy on oral care and ADL grooming has been developed. Residents have been reviewed to ensure that they are receiving appropriate ADL care, grooming, and oral care.<br>Nursing staff – nurses and NARs – will be re-trained on the elements of proper oral care for residents, ADL care, and grooming. Return demonstrations will be required to ensure adequate compliance with training.<br>A new resident dignity program has been developed which involves reviewing resident care daily to ensure that grooming has been done properly, hair combed, fingernails cleaned, proper bathing, and oral care. A form created as a checklist will be used to evaluate residents daily.<br>Unit managers or their designees will audit weekly x 4 and then monthly thereafter to ensure that the resident dignity review is being done daily; this will include on the spot observation of 10% of | 1/10/17 |

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| F 312 | Continued From page 32 hygiene.<br><br>During interview on 11/28/16, at 5:42 p.m. R42 stated she was trying to use dry shampoo on her hair and did not always even get her hair brushed on a daily basis.<br><br>During observation of morning cares on 12/1/16, at 10:13 a.m. nursing assistant (NA)-A and NA-B washed their hands and applied gloves, uncovered R42's upper body and proceeded to cleanse R42's skin folds and underarms, applying powder beneath the folds. NA-A and NA-B uncovered R42's lower body, cleaning underneath the skin folds of the abdomen and perineal area, rolled R42 on her side and cleansed her perineal area. After removing their gloves and disposing of the soiled linens into a plastic bag, licensed practical nurse (LPN)-A proceeded to provide wound care to R42's pressure ulcer, removing the soiled wound dressing materials, irrigating the wound with an antibacterial solution, cleansing her hands and proceeding to pack the wound with new dressing change materials. NA-A and NA-B completed a.m. cares after LPN-A finished dressing change. NA-A and NA-B proceeded to roll R42 onto her side and placed a magnetic wound therapy device beneath R42 and cover her up with her bed linen. LPN-A turned the magnetic device on and exited the room. NA-A and NA-B proceeded to remove their gloves and wash their hands, and exited the room without offering R42 her oral care materials nor offering to brush her hair or giving her the brush to complete it independently.<br><br>During interview on 12/1/16, at 11:13 a.m. R42 stated she would have liked to brush her hair and teeth after morning cares, "That would be kind of | F 312 | residents on random days of the week and a thorough review of the Resident Dignity Checklist to ensure that all items are being managed properly. After reviewing, the Unit Managers will deliver the checklists to the DON.<br>The Director of Nursing will report monthly to the QA Committee on this program. | |

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| F 312 | Continued From page 33<br>normal, wouldn't it?"<br><br>During interview on 12/1/16, at 11:24 a.m. registered nurse (RN)-B stated she would have expected staff to offer R42 her grooming materials to brush her hair as well as her oral care supplies with morning cares.<br><br>A policy related to activities of daily living and grooming was requested, none was provided. | F 312 | | |
| F 318<br>SS=D | 483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>(c) Mobility.<br><br>(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure range of motion (ROM) exercises were performed as recommended by the physical therapist (PT) for 1 of 2 residents (R42) reviewed for ROM and who had limited ROM.<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified a diagnosis of paraplegia. R42's annual Minimum | F 318 | Resident #42 has a new system in place to ensure physical therapy will be performed as ordered by the physician. Other residents receiving physical therapy or functional maintenance have had their programs reviewed and a system installed to ensure that they are receiving their therapy. This system is the same as that explained below, designed to correct the deficiency.<br>Nursing and therapy staff have been | 1/10/17 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET CANNON FALLS, MN 55009 |

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Continued From page 34

Data Set (MDS) assessment dated 9/23/16, indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The MDS also identified R42 required extensive to total assistance with activities of daily living and had impairments in range of motion to both lower extremities.

R42's care area assessment (CAA) for ROM printed 12/1/16, indicated R42 was totally dependent upon staff for transfers and was only able to be out of bed one hour daily due to a pressure ulcer. The CAA identified R42 had little to no voluntary movement in the bilateral lower extremities, was extensively dependent on staff in all ADLs and was alert and oriented. Proceed to care plan to maintain current level of functioning.

R42's care plan dated 12/1/16, indicated R42 had limited range of motion to the left hand secondary to paraplegia and non-use. The care plan identified R42 had multiple restorative programs in place but exhibited non-compliance and nearly daily refusals. No program was listed for lower extremity range of motion on the care plan.

R42's functional maintenance program recommendations, dated 8/19/16 indicated staff to perform passive range of motion (PROM) bilateral foot, ankle, knees and hip internal/external rotation and hip abduction/adduction x 10 [repetitions] each. Program in binder hanging on closet, initial calendar when completed. To be done 3 x/week (Sunday, Tuesday, Friday).

R42's nursing progress notes for 8/2016 - 11/2016 reflected one entry related to range of motion services, recorded on 11/17/16 at 1:38

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trained on a new method to ensure that residents receive their therapy as ordered by the physician. A calendar has been created and designated solely for resident therapy. Each unit has a copy, each unit manager, the therapy department, and the Director of Nursing. Each week, at the IDT meeting, the IDT will review the therapy calendar to ensure that resident therapies are listed there. Each shift, physical therapy and nursing check the calendar and mark off once therapy is completed. This is done for each resident to ensure that their therapy is completed.
The DON or her designee will do a weekly audit of the resident therapy calendar to ensure compliance. The head of therapy will also do his/her own weekly audit to ensure follow-through on the part of her staff.
The DON and head of therapy will report monthly to the QA Committee on this program.

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| F 318 | Continued From page 35<br>p.m. The entry indicated the exercises were unable to be performed due to unable to lift [R42's] leg.<br><br>During interview on 11/18/16, at 5:43 p.m. R42 stated she was not receiving her range of motion to her lower extremities. A functional maintenance program instruction sheet, dated 8/19/16 was taped to the front of her closet next to a calendar for staff to initial the ROM exercises labeled 9/16. No initials were signed off on the calendar and R42 stated the last time she had received the exercises was in 8/2016.<br><br>During interview on 11/30/16, at 11:31 a.m. the activities director (AD) stated that she used to be the restorative aide, however that position was eliminated and now she was assigned activities. The position had not been replaced to her knowledge and she was unsure who was doing exercises now; and the restorative/functional maintenance program participation was usually documented in Point of Care.<br><br>During interview on 12/1/16, at 8:44 a.m. licensed practical nurse (LPN)-A stated she did not perform ROM to R42's legs because she could not lift them.<br><br>During interview on 12/1/16, at 9:51 a.m. the physical therapist (PT) indicated R42 would be a credible reporter of whether or not her functional maintenance program was getting done. "She is a strong advocate for herself, if she says it is not getting done she is a reliable reporter." The PT stated the restorative aide position had been eliminated the previous summer and had not been replaced to her knowledge. The PT stated she initiated the program due to R42 having | F 318 | | |

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OMB NO. 0938-0391

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| F 318 | Continued From page 36 | F 318 | | |

trouble keeping her legs on her footrests in the wheelchair, and since R42 was not able to get up, the functional maintenance programming was very important to prevent further contractures of the lower extremities. The PT went to R42's room and performed an assessment of R42's lower ROM at this time, lifting R42's legs to perform ROM. The PT stated R42 had lost approximately five degrees of dorsiflexion in both of her feet and had increased tone and was "tight" in both legs, but had no new contractures.

When interviewed on 12/1/16, at 11:24 a.m. the registered nurse (RN)-B stated R42's lower extremity ROM was not performed because R42 was "Too heavy," and also due to R42 refusing the program.

During interview on 2/1/16, at 11:23 a.m. the director of nursing (DON) stated she was not sure why R42's restorative program for her lower extremities was not being implemented and that RN-B would be the best person to question about the lack of implementation.

Restorative program documentation was requested for R42 from Point of Care, none was provided.

The facility policy entitled Range of Motion Exercises, undated indicated the date and time the exercises were performed, name of the individual who performed the procedure, type of range of motion exercise given, whether the exercise was passive or active, length of the exercise and how the resident participated in the procedure, problems or complaints made by the resident and resident refusals should be documented in the medical record.

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| F 334 SS=E | 483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>(d) Influenza and pneumococcal immunizations<br><br>(1) Influenza. The facility must develop policies and procedures to ensure that-<br><br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br><br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br><br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br><br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br><br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br><br>(i) Before offering the pneumococcal | F 334 | | 1/10/17 |

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| F 334 | Continued From page 38<br>immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br><br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br><br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br><br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br><br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to implement the Center for Disease Control and Prevention (CDC) guidelines related to pneumococcal conjugate vaccine (PCV13) for 7 of 9 residents (R12, R1, R63, R24, R39, R29, R60) whose vaccination histories were reviewed.<br><br>Findings include:<br><br>Center for Disease Control and Prevention (CDC) identified, "Adults 65 years of age or older who | F 334 | Nursing Dept. will, upon admission, determine whether residents have received either of the pneumococcal vaccines, and retrieve dates of administration if able. Vaccinations will be recorded in the residents record as historical, and will state whether the vaccine received was PCV 23 or PCV13. If either vaccine cannot be documented, one or both vaccines as appropriate, will be offered and documented in the | |

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| F 334 | Continued From page 39<br>have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose."<br><br>R12's immunization record dated 12/1/16, indicated the 71 year old had received a pneumococcal vaccination on 3/7/2007, however, it did not indicate which vaccine was given. The current immunization record provided on 12/1/16, failed to indicate subsequent dosing of the pneumococcal vaccine was offered to R12 as recommended by CDC guidelines.<br><br>R1's immunization record, dated 12/1/16, indicated the 69 year old had received a pneumococcal vaccination on 7/1/2007, however, it did not indicate which vaccine was given. The current immunization record provided on 12/1/16, failed to indicate subsequent dosing of pneumococcal vaccine was offered to R1 as recommended by CDC guidelines.<br><br>R63's immunization record, dated 12/1/16, indicated the 74 year old had received a pneumococcal vaccination on 4/10/09, however it did not indicate which vaccine was given. The current immunization record provided failed to indicate subsequent dosing of pneumococcal vaccine was offered to R63 as recommended by CDC guidelines.<br><br>R24's immunization record, dated 12/1/16, indicated the 73 year old had received a pneumococcal vaccination on 1/1/13, however it did not indicate which vaccine was given.<br>The current immunization record provided failed | F 334 | residents records. Residents R63, R1, R12,R24, R39 and R60 will be offered PCV 23 by 1/10/2017 if not contraindicated, and offered PCV 13 by 2/10/2018. Licensed nurses will be educated at the Nursing Meeting on 1/4/2017 regarding recording which vaccine to record and that both vaccines must be offered and documented. MDS Coordinator will monitor vaccination status with each MDS Assessment completed (at least quarterly) and will update DON and Nurse Manager when vaccinations are missing from a resident's immunization record.<br><br>Completion date 1-10-2017<br>Monitored by MDS, Nurse Managers | |

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| F 334 | Continued From page 40 to indicate subsequent dosing of pneumococcal vaccine was offered as recommended by CDC guidelines.<br><br>R39's immunization record, dated 12/1/16, indicated the 99 year old had received a pneumococcal vaccination on 7/2/15, however it did not indicate which vaccine was given. The current immunization record provided failed to indicate subsequent dosing of pneumococcal vaccine was offered as recommended by CDC guidelines.<br><br>R29's immunization record, dated 12/1/16, indicated the 75 year old had received a pneumococcal vaccination on 10/25/10, however it did not indicate which vaccine was given. The current immunization record provided failed to indicate subsequent dosing of pneumococcal vaccine was offered as recommended by CDC guidelines.<br><br>R60's immunization record, dated 12/1/16, indicated the 71 year old had received a pneumococcal vaccination on 9/26/15, however it did not indicate which vaccine was given. The current immunization record provided failed to indicate subsequent dosing of pneumococcal vaccine was offered as recommended by CDC guidelines.<br><br>When interviewed on 12/1/16, at 12:52 p.m. the director of nursing (DON) indicated she was not aware of the current CDC guidelines related to the pneumococcal vaccinations. The DON confirmed resident's had not been evaluated for the a second pneumococcal vaccine per the CDC guidelines. The DON stated she thought the vaccine was given every ten years. | F 334 | | |

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| F 334 | Continued From page 41<br><br>A review of the facility policy, titled Pneumococcal Vaccine for the Superior Healthcare Management Minnesota Region was received. The policy is undated and unsigned identified "All residents will be offered pneumococcal vaccines to aid in preventing pneumococcal infections. Number 7 of the policy indicated "Administration of the pneumococcal vaccines or revaccination's will be made in accordance with current Centers For Disease Control and Prevention (CDC) recommendations at the time of the vaccination." Number 8 of the policy indicated "Inquiries concerning our facility's policies governing pneumococcal vaccinations should be referred to the Infection Preventionist or Director of Nursing Services." | F 334 | | |
| F 412 SS=D | 483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS<br><br>(b) Nursing Facilities<br><br>The facility-<br><br>(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:<br><br>(i) Routine dental services (to the extent covered under the State plan); and<br><br>(ii) Emergency dental services;<br><br>(b)(2) Must, if necessary or if requested, assist the resident-<br><br>(i) In making appointments; and | F 412 | | 1/10/17 |

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| F 412 | Continued From page 42<br><br>(ii) By arranging for transportation to and from the dental services locations;<br><br>(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide dental services for 1 of 3 residents (R72) reviewed who required routine dental services.<br><br>Findings include:<br><br>R72 had been observed and interview on 11/29/16, at 2:30 p.m. R72 was noted to have several darkened chipped and missing teeth throughout his mouth. R72 indicated he had bad teeth that included missing, chipped and decayed teeth due to his long time substance abuse of methamphetamine. R72 further included it was hard to chew, but indicated he would rather chew regular textured food than to adjust the texture. R72 stated he did not have problems with swallowing. R72 further included he had not been seen by a dentist for many years and would like to have his teeth examined, because they hurt at times.<br><br>Review of R72's admission Minimum Data Set (MDS) assessment dated 8/18/16, identified the resident as having no problems with his oral cavity and did not include R72's chipped, missing or decayed teeth. Review of the most recent quarterly MDS assessment dated 11/4/16, identified that R72 had no mouth pain, swallowing | F 412 | DSM will address oral status, MDS coordinator will double check DSM assessment for completion or oral status in Dietary Assessment with each MDS Assessment (at least quarterly). R72 to be seen by In-House dentist on 1/3/2017. Ongoing dental care schedule is maintained by In-House Services per agreement. R72's care plan has been updated.<br>All residents will be seen by in-house dental after signing the in-house service agreement, or will be encouraged to see an outside dentist if they choose not to utilize in-house services as evidenced by signed consent forms in resident records. Social worker will document decline of in-house services, and will monitor dental appointments and will update In-House Services monthly with new residents who have chosen to use In-House Dental Services.<br>Completion date 1-10-2017<br>Monitored by MDS Coordinator and Social Services | |

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| F 412 | Continued From page 43<br>or eating problems; R72's weight has been stable at 185 pounds and brushes his own teeth after set-up assistance.<br><br>Review of the most current dietary assessment for R72 dated 11/1/16, indicated the resident is on a regular diet and eats 50 percent of his meals. Weight is stable at 185 pounds . No problems with swallowing. The assessment did not include the condition of the residents teeth.<br><br>Review of R72 's oral data collection tool dated 11/1/16, identified the residents oral cavity as having no problems other than missing teeth, but refused to allow staff to complete the exam.<br><br>Review of R72's current plan of care identifies the resident as being independent with eating after set- up and receives a regular diet. Interventions: eats independently after set up assistance and obtain, record and monitor weights and fluids. R72 eats 50 percent of his meals. The care plan further indicated R72 has natural teeth and brushes them independently. The care plan did not include nor address R72's chipped, missing or decayed teeth.<br><br>Interview with the facility social service director on 11/29/16, at 2:00 p.m. who monitors and schedules needed dental exams for the residents, indicated she was aware of R72's need and desire for dental services but failed to have him seen by the on site dentist. The on-site dentist conducted exams at the facility on 10/19/16. The social service director indicated a dental appointment had not been set up nor checked into as of this time for R72. | F 412 | | |
| F 441 | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, | F 441 | | 12/27/16 |

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| F 441 SS=F | Continued From page 44<br>PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, | F 441 | | |

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| (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 441 Continued From page 45 F 441

depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to implement a comprehensive infection control program which included consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 56 residents, staff and visitors to the facility.

Findings include:

A binder was provided by registered nurse (RN)-A

The Director of Nursing and Infection Control Nurse will implement a tracking log on each unit to track antimicrobial administration, lab cultures and diseases to improve the infection control correlation by 1/1/2017. Nursing will obtain results of cultures which have been sent to lab for analysis and report results on the tracking log beginning 1/1/2017. A monthly tracking log will be maintained in the office of the infection control nurse beginning

REVISED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245304 | A. BUILDING ______ B. WING ______ | 12/01/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|

F 441 Continued From page 46

the infection control nurse on 12/1/16, at 12:35 p.m. with different tabbed sections representing each specific month of infection control monitoring. The following information was identified:

February 2016:

An order listing report identified nine different residents who had received antibiotics during the month for different diagnoses which included cellulitis, pneumonia and urinary tract infections (UTI). The report lacked room numbers, consistent documentation of organism, or if the infection was determined to be community or in-house acquired.

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

March 2016:

An order listing report identified 14 residents had received antibiotics or other medication during the month for different diagnoses which included urinary tract infection (UTI), skin, bronchitis and yeast. The report lacked room numbers, organism cultures or if the infection was determined to be community or in-house acquired.

Seven of the fourteen residents had UTI. A resident was treated with Cipro 250 mg by mouth twice daily from 3/8-3/14/16. The urine culture revealed no growth or an organism identified.

F 441

the month of January, 2017; compliance will be monitored through the use of the monthly tracking log. The evening Nurse manger will review the unit logs weekly for completion, copy and give to the infection control nurse beginning 1/1/2017. Staff nurses will be educated on procedure and review policy at the nursing meeting on 1/4/2017
Completion date 12-28-2016
Monitored by Director of Nursing and Infection Control Nurses

REVISED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 441 | | F 441 | | |

Continued From page 47

Another resident was treated with Levaquin 500 mg daily for 7 days for prophylaxis without an identified type of infection or culture results documented on the report. Another resident had "? infection" listed with not culture results documented on the report. This resident was treated with Levaquin 500 mg by mouth daily for 5 days.

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

April 2016:

An order listing report identified 12 infections where residents had received antibiotics during the month. Two of the 12 had sites of infection documented, the others were blank. The report lacked any room numbers, type of infection, any documentation of organism, consistent date of resolution or if the infection was determined to be community or in-house acquired.

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

May 2016:

An order listing report identified 15 infections where residents had received antibiotics during the month. Three of the 15 had sites of infection

REVISED

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|---|---|---|---|---|
| F 441 | Continued From page 48 | F 441 | | |

documented, the others were blank. The report lacked any room numbers, type of infection, any documentation of organism, consistent date of resolution or if the infection was determined to be community or in-house acquired.

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

June 2016:

An order listing report identified 18 infections where residents had received antibiotics. There were documented sites of infection and more detail related to the use of Bactroban, and Nystatin. The report lacked consistent date of resolution or if the infection was determined to be community or in-house acquired.

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

July 2016:

An order listing report identified 6 infections where residents had received antibiotics. There were no documented sites of infection. The report lacked room numbers, type of infection, any documentation of organism, consistent date of resolution or if the infection was determined to be community or in-house acquired.

REVISED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET CANNON FALLS, MN 55009** |

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|---|---|---|---|---|
| F 441 | Continued From page 49 | F 441 | | |

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

August, September, October and November 2016:

No order listing report was provided.

When interviewed on 12/1/16, at 12:52 p.m. the director of nursing (DON) confirmed the past four month of reports didn't exist. When asked about an antibiotic stewardship program, the DON was not aware of it and had not implemented anything related to antibiotic reeducation. Further, the DON stated the infection control program lacked consistent monitoring, trending or analysis of the collected data, adding "We have to enhance our program."

During the interview, the DON stated infections were discussed at their Monday through Friday clinical rounds but there was not any processes for tracking or trending.

Infection Control policy was requested but not received.

REVISED

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 245304 (Y1) | A. Building<br>B. Wing (Y2) | 1/19/2017 (Y3) |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET<br>CANNON FALLS, MN 55009 |

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).

REVISED

| ITEM (Y4) | DATE (Y5) | ITEM (Y4) | DATE (Y5) | ITEM (Y4) | DATE (Y5) |
|---|---|---|---|---|---|
| ID Prefix F0166<br>Reg. # 483.10(j)(2)-(4)<br>LSC | Correction Completed 01/10/2017 | ID Prefix F0241<br>Reg. # 483.10(a)(1)<br>LSC | Correction Completed 01/10/2017 | ID Prefix F0242<br>Reg. # 483.10(f)(1)-(3)<br>LSC | Correction Completed 01/10/2017 |
| ID Prefix F0278<br>Reg. # 483.20(g)-(j)<br>LSC | Correction Completed 01/10/2017 | ID Prefix F0279<br>Reg. # 483.20(d);483.21(b)(1)<br>LSC | Correction Completed 01/10/2017 | ID Prefix F0282<br>Reg. # 483.21(b)(3)(ii)<br>LSC | Correction Completed 01/10/2017 |
| ID Prefix F0285<br>Reg. # 483.20(e)(k)(1)-(4)<br>LSC | Correction Completed 01/10/2017 | ID Prefix F0309<br>Reg. # 483.24, 483.25(k)(l)<br>LSC | Correction Completed 01/10/2017 | ID Prefix F0312<br>Reg. # 483.24(a)(2)<br>LSC | Correction Completed 01/10/2017 |
| ID Prefix F0412<br>Reg. # 483.55(b)(1)(2)(5)<br>LSC | Correction Completed 01/10/2017 | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) GPN/kfd | DATE 2/2/2017 | SIGNATURE OF SURVEYOR 37476 | DATE 1/19/2017 |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 12/1/2016 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 2C84
Facility ID: 00758

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245304**

2. STATE VENDOR OR MEDICAID NO. (L2) **847972200**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE GARDENS AT CANNON FALLS**
(L4) **300 NORTH DOW STREET**
(L5) **CANNON FALLS, MN** (L6) **55009**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **12/20/2013**

6. DATE OF SURVEY **12/01/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **74** (L18)
13.Total Certified Beds **74** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 74 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Jaeckels, HFE NE II 01/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/26/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00270** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 16, 2016

Mr. Thomas Paul, Administrator
The Gardens at Cannon Falls
300 North Dow Street
Cannon Falls, Minnesota 55009

RE: Project Number S5304026, H5304033, H5304034, H5304036

Dear Mr. Paul:

On December 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed. In addition, at the time of the December 1, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5304033, H5304034, that were found to be unsubstantiated and an investigation of complaint number H5304036, that was found substantiated at deficiency cited at F309.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731     Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited are cited on the current survey and on any survey within the last two calendar years. A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) was cited on the abbreviated standard survey completed on December 7, 2015. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following Category 1 remedy:

- State Monitoring effective December 21, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 1, 2017. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, The Gardens at Cannon Falls is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 1 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met.

Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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 remedy be imposed:

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

## 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 their respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 March 1, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **245304** | A. BUILDING ______ B. WING ______ | **12/01/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET CANNON FALLS, MN 55009** |

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| F 000 | INITIAL COMMENTS<br><br>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.<br><br>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.<br><br>"A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey."<br><br>An investigation of complaints H5304036 were completed. This complaint was substantiated at F309.<br><br>An investigation of complaint H5304034 was completed during the survey and found not to be substantiated.<br><br>An investigation of complaint H5304033 was completed during the survey and found not to be substantiated. | F 000 | | |
| F 166<br>SS=D | 483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. | F 166 | | 1/10/17 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 12/27/2016

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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| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET CANNON FALLS, MN 55009** |

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(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing

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| F 166 | Continued From page 2 | F 166 | | |

written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident’s grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident’s concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents’ rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents’ rights within its area of responsibility; and

(vii) Maintaining evidence demonstrating the

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| F 166 | Continued From page 3<br>result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure follow-up investigation into a complaint grievance in regards to missing electric razor for 1 of 2 residents (R34) reviewed for missing personal property.<br><br>Findings include:<br><br>R34's quarterly Minimum Data Set, dated 11/1/16 identified a Brief Interview for Mental Status score of 13 (cognitively intact).<br><br>During interview on 11/28/16, at 5:25 p.m. R34 stated he had been missing his electric razor for about two weeks, and was not sure if staff were looking for it. Although he had reported it to a nursing assistant staff, no one had gotten back to him.<br><br>During interview on 11/29/16, at 3:15 p.m. the social worker (SW)-A stated there should be a form filled out on any missing resident items. SW-A further stated that nursing assistants should fill them out if they are told a resident has lost something and it is not located. SW-A then provided the missing item reports for the previous nine month period at this time, consisting of only two reports. Neither of the reports were for R34's razor.<br><br>During interview on 11/30/16, at 11:18 a.m. registered nurse (RN)-B stated she was unaware R34 was missing a razor. Any staff member who was aware an item was missing should fill out a | F 166 | R34's family has been notified, and are purchasing a new razor for the resident. The facility has drafted a new policy and procedure on the filing of grievances and will present it to all residents and families upon admission. It will be presented at the next resident council meeting. The residents' families will be mailed copies of the new resident grievance and lost items forms. These forms are also now included in the admissions packets. All grievances will be tracked and monitored weekly. Families and residents will be notified of findings.<br>This will be monitored by the Director of Social Service and will be completed by 1-1-2017 | |

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| F 166 | Continued From page 4<br>complaint form for the missing item and turn it in to social services. RN-B stated R34 was shaved for Veteran's Day and would likely have had it then.<br><br>During interview on 11/30/16, at 11:20 a.m. licensed practical nurse (LPN)-A stated she was aware activities had given R34 a razor a while ago and now it was missing, but could not state the date she had been informed it was gone.<br><br>During interview on 11/30/16, at 11:31 a.m. the activities director (AD) stated R34 was missing a brand new razor he had gotten and that it had happened within the last month. The AD stated she had wanted to purchase R34 a new one, however did not have the funds in her budget the last time she went on a shopping trip. The AD stated it was on her list to purchase at a future date. The AD was not aware of any missing item reports filled out for the razor.<br><br>The facility policy entitled Lost and Found, undated, stated resident or family complaints of missing items must be reported to the Director of Nursing Services, and reports of misappropriation or mistreatment of resident property are immediately investigated. | F 166 | | |
| F 241 SS=D | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced | F 241 | | 1/10/17 |

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| F 241 | Continued From page 5<br>by:<br>Based on observation, interview and document review, the facility failed to ensure a dignified environment for 1 of 1 resident (R42) reviewed for dignity whose urinary incontinence supplies and catheter bag were left exposed and uncovered in her room.<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified diagnoses of paraplegia and urinary retention.<br><br>R42's annual Minimum Data Set, dated 9/23/16 identified a Brief Interview for Mental Status score of 15 (cognitively intact).<br><br>During interview on 11/28/16, at 5:43 p.m. R42 stated she was not always treated with respect and dignity. R42 indicated she did not like her catheter bag being left uncovered and her incontinence products being left out for anyone entering the room to see. R42's catheter bag was visualized at this time to be hanging on the end of her bed, uncovered with urine present in the bag. A box of gloves and incontinence wipes was sitting on top of her bedside stand. R42 further stated she rarely got out of bed due to having a pressure ulcer on her bottom that required frequent repositioning.<br><br>During observation on 11/30/16, at 3:51 p.m. R42's catheter bag was uncovered with urine draining into the bag and an incontinence pad was lying out on her bedside stand.<br><br>During observation on 12/1/16, at 10:13 a.m. R42 was assisted with morning cares. Nursing assistant (NA)-A and NA-B proceeded to assist | F 241 | Per resident request, Resident R42 has met with Social Worker, Nurse Manager, Ombudsman and DON to review care plan on 12/28/2016.<br>The admission nurse will put order in PCC upon admission for patients with catheters to ensure catheter bag is covered every shift and all residents /patients with catheters will have order added to PCC order portal on 12/21/2016.<br>An audit will be developed and will be performed weekly by evening Nurse Manager to ensure that incontinence products, gloves, etc. are out of view of visitors/other residents and all catheter bags are covered when cares are not being performed. Staff meeting minutes on 1/4/2017 will include reviewing resident dignity policy.<br>This will be monitored by the Nurse Managers and DON | |

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| F 241 | Continued From page 6<br>R42 with washing the top half of her body, then applying a clean gown and washing her lower half and providing incontinence care. At 10:37 a.m., Licensed practical nurse (LPN)-A proceeded to complete wound care on R42's pressure ulcer. At 10:54 a.m., R42's morning cares were completed and all staff exited R42's room. An incontinence pad was lying on R42's bedside stand along with some gloves, and her urinary catheter was exposed without a cover on it, hanging at the end of her bed. Dark amber urine was present in the bag.<br><br>During interview on 12/01/16, at 11:13 a.m. R42 stated it bothered her that the catheter bag was left out and incontinence supplies were on her bedside stand, as she was unable to pick them up herself. R42 stated anyone who stopped by her room would be able to see them and know she had bowel and bladder issues, and she did not feel she should have to remind staff to pick them up.<br><br>During interview on 12/1/16, at 11:24 registered nurse (RN)-B stated she would have expected R42's catheter bag be covered whenever she was out of the room, but not necessarily in bed. RN-B confirmed that incontinence products being left out was undignified.<br><br>During interview on 2/1/16, at 11:23 a.m. the director of nursing (DON) stated that incontinence products should not be left out in resident rooms, but stated as long as a urinary catheter bag didn't face the hallway it might be okay.<br><br>A facility policy was requested related to activities of daily living and provision of dignified services, none was provided. | F 241 | | |

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| F 242 SS=D | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 2 of 3 residents (R42 & R11) reviewed for choices received baths according to their preferences for bathing frequency.<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified a diagnoses of paraplegia and urinary retention.<br><br>R42's annual Minimum Data Set (MDS), dated 9/23/16 indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact).<br><br>R42's care area assessment (CAA) for activities of daily living (ADL), printed 12/1/16 indicated R42 was totally dependent upon staff in all ADL and was alert and oriented. Proceed to care plan to maintain current level of functioning. | F 242 | Admission assessment updated to include questions of preference of bath/shower, time (day/evening) for weekly bath /shower. Extra weekly bath/showers can be accommodated based on staff scheduling. Review of bath/shower schedule by DON/Nurse Managers monthly to ensure consistency of bath schedule on Kardex and in care plan.<br><br>Nurse meeting agenda on 1/4/2017 included education of documenting bath/shower body audit and refusals. Nurse Manager to conduct weekly audits on Refusal to ensure body audits are completed and documentation of baths given and or refused. Bath audit assessment updated to include nurse documentation of bath/shower given or | 1/10/17 |

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| F 242 | Continued From page 8 | F 242 | refused. | |

R42's care plan, dated 12/1/16 indicated R42 required assistance of two staff for bathing and should receive a bed bath weekly and as needed (PRN).

R42's nursing admission assessment, dated 3/9/16 did not identify how often R42 preferred a bath.

During interview on 11/28/16, at 5:42 p.m. R42 stated she was not bathed according to her preferences and had not been asked how often she would like a bath, and receiving extra baths was "not encouraged." R42 stated she was trying to use dry shampoo on her hair and did not always even get her hair brushed on a daily basis.

During follow up interview on 12/1/16, at 10:12 a.m. R42 stated she would like a bath a couple of times per week if possible, however she was aware it took a lot of time for the staff. R42 stated she thought she was told this would be an extra charge at one point during her stay.

During interview on 12/1/16, at approximately 2:30 p.m. the social worker (SW)-A indicated all residents were asked about bathing frequency on their admission nursing assessment, any documentation of such should be included on this form.
R11 had been interview on 11/30/16, at 11:38 a.m. the resident indicated she had not had a bath for the past 2 weeks. R11 included she thought the staff were too busy to give her a bath during these times. R11 further included she would like a bath at least weekly.

Review of the current quarterly Minimum Data

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| F 242 | Continued From page 9 | F 242 | | |

Set (MDS) dated 10/28/16, indicated R11's bathing did not occur during this assessment period. R11 receives 1 assistance with bathing. The resident's brief interview for mental status BIMS score was 15 out of 15 (meaning cognition is intact).

Review of the most current plan of care for R11, identifies the resident as having an activities of daily living self -care deficit related to being easily fatigued, strength decrease, history of falls, muscle weakness and atrophy. Interventions; requires 2 assistance with bathing, washing and transfers. Staff to wash hair and do nail care.

Review of the weekly bathing sheets for the past month, indicated R11 received a bath on 10/30/16, 11/5/16 and 11/12/16, but did not include bathing for the weeks of 11/19/16 or 11/26/16.

Interview with the facility MDS coordinator on 11/30/16, at 11:41 a.m. confirmed R11 did not receive a bath during the MDS quarterly assessment period dated 10/28/16. The MDS coordinator also included that she had not not investigate as to why the resident did not receive a bath during this time.

Interview with registered nurse (RN)-B a nurse manager on 11/30/16, at 1:35 a.m. confirmed there was no documentation that R11 had received a bath in the past 2 weeks. She also confirmed R11's skin checks during bathing had not been completed as well.

Interview with nursing assistants (NA)-C, NA-D and NA-E on 11/30/16, at 1:43 p.m. indicated they were primary caregivers for R11's wing and

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| F 242 | Continued From page 10<br>confirmed the resident receives a weekly bath on Saturdays, but could not verify a bath had been given.<br><br>A policy regarding bathing was requested, none was provided. | F 242 | | |
| F 243 SS=E | 483.10(f)(5)(i)-(iii)(6)(7) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP<br><br>(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br><br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br><br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br><br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br><br>(f)(6) The resident has a right to participate in family groups.<br><br>(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document | F 243 | The facility staff will adhere to the | 1/10/17 |

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| F 243 | Continued From page 11<br>review the facility failed to allow the resident council to meet privately without staff in attendance at the resident council meetings<br><br>Findings include:<br><br>R40 had been interviewed on 11/30/16, at 9:00 a.m. as she was designated council president. R40 indicated the resident council meets on a monthly basis and that she leads the meetings along with the facility activity director. R40 indicated the activity director takes notes and will assist with discussions/concerns that the residents may have. R40 further included that the resident council has not had the option to meet privately. R40 indicated she has suggested to the activity director in the past when she had a concern to meet privately during the resident council meeting. R40 indicated the activity director had told her she needed to stay for the entire meeting to take notes on everything that is discussed. R40 stated there was a resident council meeting on 12/1/16, and she was going to bring it to the activity directors attention again.<br><br>Observation of the resident council meeting on 12/1/16, at 2:30 p.m. R40 asked the activity director if she would leave the room during their meeting if the council wanted to talk privately. The activity director indicated she needed to stay to take notes so they could be discussed with the facility directors and that there would have to be a vote on if this could take place. The activity director indicated this concern could be discussed at a later date.<br><br>Interview with the activity director on 12/2/16, at 10:23 a.m. confirmed that she has not allowed the resident council to meet privately when | F 243 | decision of the resident council regarding attendance at Resident Council meetings. A staff person will take minutes of the council proceedings only if requested by the Resident council. Residents will vote on whether they wish for staff to be present. Staff will continue to take minutes on a monthly basis until the resident council votes that they do not wish a staff person to take minutes. Management staff will continue to be present by invitation only as is the current practice.<br>The Executive Director or his designee will monitor compliance by reviewing the minutes and attendance of the Resident Council meetings within 5 business days after each meeting of the Resident Council to ensure that approval has been given by the Resident Council for any visiting staff members, and to ensure continued compliance with the program. This audit will be a continuous audit. The Executive Director will report the results of this audit to the QA Committee monthly.<br>Completion date 1-1-2017 | |

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| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET CANNON FALLS, MN 55009** |

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| F 243 | Continued From page 12<br>requested. She further indicated that she did not know this was a choice for the residents and that she thought she needed to stay to take notes.<br><br>A policy was requested concerning resident council but none provided. | F 243 | | |
| F 253 SS=E | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to maintain a clean, sanitary environment, and resident rooms in good repair, for residents, staff and visitors. This had the potential to affect 12 residents on the two hundred wing.<br><br>Findings include:<br><br>Observations noted during the initial tour on 11/28/16, and verified on 12/1/16, at 12:50 p.m. with the environmental director (ED) were as follows:<br><br>During the initial tour on 11/28/16 at 2:48 p.m., a strong pungent odor was present in the hallway located at the nurses station on the 200 wing.<br><br>On 11/30/16 at 2:48 p.m. R42 complained to the surveyor "the carpet smells of pee, and becomes unbearable, especially in the summer, they know about it [in regards to telling staff of the smell]."<br><br>The strong pungent odor of urine in the hall by the | F 253 | Carpet odor in 200 wing: Entire length of the hall was cleaned and disinfected. Housekeeping and Maintenance will monitor on a daily basis and clean areas that are soiled or have odors of urine. Nursing will monitor the residents on the 200 wing who are known for having incontinence problems and are mobile in the hallways and change residents who may have soiled clothing. Rooms are cleaned daily and those rooms with odors issues will be checked more than daily to ensure odors are maintained at an acceptable level.<br>R13 wheelchair and R35 wheelchair were cleaned. A policy and procedure for cleaning wheelchairs will be developed and implemented. The policy will require the nursing staff to notify the housekeeping staff when a wheelchair is in need of cleaning. Nursing will label the wheelchair with the resident's name and take it to the housekeeping department where it will be cleaned and then returned | 1/10/17 |

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| F 253 | Continued From page 13<br>nurses station, and also outside of rooms on the 200 wing, was noted during the survey on 11/28/16 at 2:48 p.m., 11/30/16 at 10:47 a.m., 11/30/16 at 2:48 p.m., and 12/1/16 at 10:15 a.m.<br><br>On 11/30/16 10:47 a.m. an observation revealed that the carpet was soiled heavily with debris the length of the 200 hallway with multiple stains, also the door strips to the rooms had grime, dirt and debris. Hallway carpet located outside R23 had a large white stain. Food debris was observed to be located directly outside of R4's room.<br><br>R13's wheelchair was observed to be soiled, a substance that appeared to be nuts was built up in the foot pedals, brown debris was visible and the chair upholstery felt sticky to the touch.<br><br>R35's wheelchair was observed to be soiled with debris, the foot plate of the chair was soiled with dried on food and debris.<br><br>R81 was interviewed on 11/29/16 at 10:51 a.m., and stated, "I feel that my room is filthy." R81's bedroom floor was observed to have dry and wet puddles of a brown amber liquid. The floor revealed surface damage, the appearance in the wax surface was uneven. In R81's bathroom the faucet was leaking and the sink had stained rusty orange across the bowl. The tile is stained brownish red all along the outside edges extending 6-8 inches into the center of the floor. R81 stated, "It is easy to see that the stool needs a new seal, I don't know why they don't just fix it." The bathroom also had a strong malodorous smell which was concentrated by the entryway to the room.<br><br>On 11/30/16 at 2:21 p.m., the housekeeper | F 253 | to the nursing department. Nursing will monitor this daily.<br>R81 sink and stool were cleaned and new gaskets have been installed. Floor was cleaned. All bathrooms are cleaned on a daily basis and housekeeping will notify maintenance of repairs which need to be conducted to ensure that broken items are repaired and missing items are replaced. Monitored by housekeeping and maintenance daily.<br>R34 privacy curtain was replaced, walls were patched, sanded and painted. Nursing, housekeeping and maintenance staff will check rooms daily and on a random basis for torn or soiled curtains and privacy curtains. When a room is vacant, housekeeping does a deep cleaning and replaces the privacy curtains.<br>R4 walls were patched, sanded and painted and ceiling tile was replaced. Maintenance and housekeeping will monitor rooms during cleaning on a daily basis and note areas that need repair and inform maintenance by writing needed repairs in the maintenance log on each nursing station.<br>R35 ceiling tile was replaced. Housekeeping, maintenance and nursing will monitor for ceiling tile repairs and note in the maintenance log on each nursing unit to notify maintenance of needed repairs.<br>R15 blinds were replaced. Maintenance and housekeeping will monitor rooms when they are being cleaned on a daily basis for items that need to be repaired or replaced and will note items on the | |

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| F 253 | Continued From page 14<br>(HC)-A was interviewed. She stated that she has mopped the room today, and that the floor recently had a deep cleaning. She confirmed that there is a strong urine odor.<br><br>On 11/30/16 at 2:30 p.m. R34 privacy curtain is soiled and stained with a reddish brown color substance 4 feet off of the floor. The walls were heavily scraped with missing paint and surface damage behind the chair and the bed.<br><br>On 11/29/16 at 11:16 a.m. during a interview with R4, the ceiling tile is observed to be discolored, and bowing away from the strip where the heat register is located. The walls in the bathroom have patches of plaster, they are not painted. There is a 2 inch piece of ceiling tile missing.<br><br>On 11/28/16 at 6:13 p.m. during the initial interview with R35, cracked ceiling tile is observed in the bathroom.<br><br>During a interview with R15 on 11/28/16 at 6:49 p.m. 5 inch strips of blinds are observed to be missing from the window.<br><br>On 11/28/16 at 4:44 p.m. during a interview with R 72, the bathroom towel holder is missing, the wall is damaged, where it was hanging. R72 states that he notified the staff 6 weeks ago.<br><br>On 11/28/16 at 4:44 p.m. R13 wheelchair had been found to be soiled with debris. The foot pedals have ground in brown food debris, the seams of the wheelchair had a layer of dried food debris.<br><br>On 12/1/16 at 12:30 p.m. Wall paper in the hallway between room 217-219, and | F 253 | maintenance logs on each nurses station to notify maintenance of needed repairs or replacements.<br>Wall paper in the 200 wing hallway was patched and repaired where the wall board was exposed. All building hallways and rooms where wallpaper is on the surface will be monitored by housekeeping and and maintenance on a daily basis as they work throughout the building. Existing damage to walls will be patched and painted.<br>Monitored by Maintenance, Housekeeping and Administration | |

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| F 253 | Continued From page 15<br>rooms 201-230 had multiple torn/scraped off in multiple areas revealing the wallboard below.<br><br>On 12/1/16 at 12:30 p.m. in the dining room there was a 5 inch x 16 foot long black mark along the wall, ceiling tiles were noted to have pieces missing. There is a 18 inch by 4 foot area where the wall is damaged. The wall paper was missing through out revealing a damaged wall board below. There was a thick layer of plaster applied but had not been smoothed nor painted.<br><br>During the tour on 12/1/16 at 1:30 p.m., the ED verified the housekeeping staff cleaned each room and bathroom daily. He confirmed that the carpet should be replaced and that it was discussed in a meeting, but not budget approved. The ED stated the housekeepers and nursing staff were responsible to report when repairs were needed. When in the 200 wing the ED presented a clip board that was used for communication, when there were environmental issues in need of repair. There were no notes on the communication board.<br><br>A policy for building maintenance was requested on 12/1/16 at 2:00 p.m. The ED presented a paper titled maintenance repair list. He was unaware of a policy for maintenance. | F 253 | | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate | F 278 | | 1/10/17 |

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| F 278 | Continued From page 16<br>participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>(2) Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1 resident (R45) reviewed for oral/ nutritional needs.<br><br>Findings include:<br><br>R45's Minimum Data Set (MDS) 5 day assessment dated 10/14/16, identified the | F 278 | A modification of the 14 day MD for R45 was submitted the day it was noted by the survey team. The MDS Coordinator will review and check all the section of the MDS For accuracy of other departments entries and confirm the information with the care plan with each MDS (at least quarterly).<br>Completion date 1-10-2017<br>Monitored by the MDS Coordinator | |

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| F 278 | Continued From page 17 resident as having a mechanically altered diet. R45's MDS 14 day assessment dated 10/19/16, identified the resident as having tube feedings and mechanically altered diet.<br><br>During an observation on 11/29/16, at 8:59 a.m. R45 was observed to be feeding herself independently hot oatmeal cereal and had a breakfast tray with other regular foods and liquids located on the tray.<br><br>When interviewed on 11/30/16, at 2:00 p.m. the dietary manager (DM) verified R45 never had a feeding tube and confirmed it was an inaccurate coding on the MDS dated 10/19/16. | F 278 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive | F 279 | | 1/10/17 |

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| F 279 | Continued From page 18<br>care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.<br><br>(iv)In consultation with the resident and the resident’s representative (s)-<br><br>(A) The resident’s goals for admission and desired outcomes.<br><br>(B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by: | F 279 | | |

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| F 279 | Continued From page 19<br>Based on interview and document review, the facility failed to develop a comprehensive plan of care for 1 of 2 residents (R72) who had a history of substance abuse and possession of illegal drugs.<br><br>Findings include:<br><br>R72's progress notes dated 10/3/16, indicated R72 had a canister of marijuana in his room. The note indicated the resident attempted to hide the canister when he found out the staff called the police, due to his possession of an illegal substance in the facility. The progress note further indicated the police confirmed the canister contained the illegal substance of marijuana. Review of the progress notes dated 11/8/16, indicated R72 was observed to have a marijuana pipe in his room, while the police were at the facility investigating a complaint. The note further included the police tested the pipe and it was confirmed for marijuana.<br><br>Review of R72's diagnosis list obtained from the admission diagnosis sheet included; alcohol abuse with intoxication, psychoactive substance abuse, major depressive disorder, adjustment disorder with anxiety and personality disorder.<br><br>Review of R72's admission Minimum Data Set (MDS) dated 8/18/16, indicated the resident had diagnosis that included psychoactive substance abuse along with alcohol abuse.<br><br>Review of R72's current plan of care did not include the residents history of drug abuse nor did it include monitoring for possession of illegal substances. | F 279 | Care plan for R72 has been reviewed and updated to include focus, goals and interventions with history of and potential current use of illegal substances. Nursing order added to PCC for nurse to observe for sign of substance abuse and possession which include notifying local authorities if illegal substances are identified, which will protect other residents. Newly discovered issues will be added to the individualized plan of care by the appropriate department as they are discovered. Nurse manager to review resident's chart weekly or more frequently for notes regarding illicit substance abuse and/or presence.<br>Completion date 2-1-2017<br>Monitored by Nurse Managers, DON and MDS Nurse | |

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| F 279 | Continued From page 20<br>Interview with the director of nursing (DON) on 12/2/16, at 1:00 p.m. confirmed the plan of care did not include monitoring for R72's history or possession of illegal substances. | F 279 | | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R42) reviewed for activities of daily living was provided assistance with oral hygiene and grooming in accordance with the care plan.<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified a diagnosis of paraplegia.<br><br>R42's annual Minimum Data Set (MDS), dated 9/23/16 indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The MDS also identified R42 required extensive assistance of two staff for grooming activities.<br><br>R42's care area assessment (CAA) for activities of daily living (ADLs), printed 12/1/16 indicated R42 was totally dependent upon staff in all ADLs and was alert and oriented. Proceed to care plan | F 282 | R42’s care plan updated to reflect that resident is able to dictate personal cares and will be encouraged to perform her own cares and when unable to request that staff assist her.<br><br>Resident R42 has been included in the new resident dignity grooming program. Residents have had their care plans reviewed and grooming and ADL corrections were made as necessary. Nursing will be inserviced by 1/10/17 on proper care planning to address ADLs and the new resident dignity grooming program.<br>A new care planning program has been put into place that includes a strong focus on grooming and ADLs. A new resident dignity grooming checklist has been developed. This checklist will be used on a daily basis to evaluate and ensure that | 1/10/17 |

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| F 282 | Continued From page 21<br>to maintain current level of functioning.<br><br>R42's care plan, dated 12/1/16 indicated R42 required assistance of one staff member to set up supplies and assist her for oral care, and assistance of one staff in all other areas of hygiene. The care plan also indicated R42 was to get her hair washed one additional time weekly on her request, not a full bath, rather just a hair wash.<br><br>During interview on 11/28/16, at 5:42 p.m. R42 stated she was trying to use dry shampoo on her hair and did not always even get her hair brushed on a daily basis.<br><br>During observation of morning cares on 12/1/16, at 10:13 a.m. nursing assistant (NA)-A and NA-B washed their hands and applied gloves, uncovered R42's upper half and proceeded to cleanse R42's skin folds and underarms and apply powder beneath the folds. NA-A and NA-B uncovered R42's lower half of her body, cleaning underneath the skin folds of the abdomen and perineal area, rolled R42 on her side and cleansed her perineal area. After removing their gloves and disposing of the soiled linens into a plastic bag, licensed practical nurse (LPN)-A proceeded to provide wound care to R42's pressure ulcer, removing the soiled wound dressing materials, irrigating the wound with an antibacterial solution, cleansing her hands and proceeding to pack the wound with new dressing change materials. When completed, LPN-A removed the soiled dressing materials. NA-A and NA-B proceeded to roll R42 onto her side and set a magnetic wound therapy device underneath R 42 and cover her up with her bed linen. LPN-A turned the magnetic device on and exited the | F 282 | residents are receiving proper grooming and ADL care according to care plan. Unit managers will audit 10% of residents weekly x 4 weeks and then monthly thereafter to ensure that the new resident dignity grooming checklist is being properly used. All completed checklists will be delivered to the DON for review by her or her designee.<br>The DON or her designee will report to the QA committee monthly. | |

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| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET CANNON FALLS, MN 55009 |

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| F 282 | Continued From page 22<br>room. NA-A and NA-B proceeded to remove their gloves and wash their hands, and exited the room without offering R42 her oral care materials nor offering to brush her hair or giving her the brush.<br><br>During interview on 12/1/16, at 11:13 a.m. R42 stated she would have liked to brush her hair and teeth after morning cares, "That would be kind of normal, wouldn't it?"<br><br>During interview on 12/1/16, at 11:24 a.m. registered nurse (RN)-B stated she would have expected staff to offer R42 her grooming materials to brush her hair as well as her oral care supplies with morning cares.<br><br>A policy related to activities of daily living and grooming was requested, none was provided. | F 282 | | |
| F 285 SS=D | 483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR<br><br>(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident’s assessment, care planning, and transitions of care.<br><br>(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a | F 285 | | 1/10/17 |

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| F 285 | Continued From page 23<br>significant change in status assessment.<br><br>(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br><br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br><br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br><br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br><br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br><br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br><br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. | F 285 | | |

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| F 285 | Continued From page 24 | F 285 | | |

Continued From page 24

(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as

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| F 285 | Continued From page 25<br>described in 435.1010 of this chapter.<br><br>(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 2 of 4 residents (R56, R81) reviewed for preadmission screening who had history of serious mental illness (MI) had a Level II preadmission screening and resident review (PASRR) on file.<br><br>Findings include:<br><br>R56's face sheet, dated 11/30/16 indicated primary diagnoses of schizophrenia and major depressive disorder.<br><br>An initial pre-admission screening from the Senior Linkage Line, dated 10/12/16 indicated a primary diagnosis of schizophrenia and a history of mental illness.<br><br>A social services progress note, dated 10/13/16 indicated staff were waiting on Olmsted County related to the Level II PASRR screen. No follow-up phone calls or additional documentation was charted or provided to surveyor.<br><br>During interview on 11/28/16, at 7:02 p.m. R56 stated he routinely saw a psychiatrist for mental health issues and had been in an inpatient treatment facility for approximately ten years. | F 285 | Social Worker has notified Goodhue County that Level II screenings are required for R56 and R81, and is awaiting completion and delivery of screenings. Call placed weekly to check on progress while awaiting screenings. Level I pre-admission screening will be reviewed or completed as needed by Admissions prior to admission. Admissions will report to Social Services if level II screening is indicated. Social Worker will notify the appropriate county to complete level II screening. Tracking log to be kept in Social Services office, monitoring to be completed by Social Worker with each MDS Assessment (at least quarterly).<br>Completion date 1-10-2017<br>Monitored by MDS and Social Services | |

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During interview on 11/29/16, at 3:44 p.m. the social worker (SW)-A confirmed R56 met criteria for a Level II PASRR and had been admitted from another facility in 10/16. SW-A indicated she had called the county previously to check on the PASRR, but was unsure of the status and did not have one on file for R56.

On 11/30/16, at 9:10 a.m. a Level II PASRR form for R56 was faxed to SW-A from Goodhue County, indicating R56 had documented history of mental illness and did not need specialized services.

During interview on 11/30/16, at 9:14 a.m. R56's previous county case worker (CW)-A stated R56 did require mental health services which had been set up in his present county of residence and would not require any other specialized services. CW-A was not sure of the status of the PASRR assessment.

R81's face sheet, dated 12/01/2016, indicated primary diagnoses bipolar disorder and schizophrenia. The electronic medical record (EMR) included schizophrenia, dated 7/19/16, listed under the diagnosis tab.

An initial pre-admission screening from the Senior Linkage Line, dated 7/18/16, indicated a primary diagnosis of bipolar disorder. The box was checked for the following "The OBRA (Omnibus Budget Reconciliation Act [This is a federal program that requires the identification of individuals with serious Mental Illness (MI) or Developmental Disabilities (DD) indicators who are requesting admission to a nursing facility (NF) to determine the most appropriate care setting and services]) Level 1 Screening indicated a

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| F 285 | Continued From page 27<br>Level II Mental Health Evaluation and final review of the need for specialized services is required."<br><br>On 11/29/16, at 5:07 p.m., SW-A was interviewed regarding the lack of a Level II Pre-Admission Screening and Resident Review (PASRR) screening. The Senior Linkage Line document was reviewed with the SW-A. The SW-A stated the need for the Level II screening was missed and confirmed there was not one on file.<br><br>On 11/29/16, at 5:30 p.m. the administrator, director of nursing and admission coordinator were together in the administrator's office. When interviewed , they stated they were not aware of R81 lacked a Level II PASRR.<br><br>On 12/1/16, at 10:57 a.m. an unsigned Level II PASRR form, from Goodhue County, for R81 was faxed to the SW-A. The form indicated R81 had documented history of mental illness and did not need specialized services.<br><br>A policy related to PASRR assessments was requested, none was provided. | F 285 | | |
| F 309 SS=G | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. | F 309 | | 12/27/16 |

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| F 309 | Continued From page 28<br>483.25<br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure narcotic pain medication to control chronic moderate to severe pain was available timely for 1 of 1 resident (R42) reviewed for pain control. R42 experienced actual harm when the facility was out of the narcotic medication supply for three days before the pharmacy provided the medication, during which time R42 experienced severe pain.<br><br>Findings include:<br><br>R42's face sheet dated 12/1/16, identified diagnoses of paraplegia, neuropathy and chronic pain syndrome.<br><br>R42's annual Minimum Data Set (MDS) dated 9/23/16, indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. The MDS also indicated R42 received as needed pain medications and experienced moderate pain that interfered with daily activities. | F 309 | Resident #42 was seen by a physician for pain and a new program was put into place to ensure that pain medications are always available.<br>Under the direction of the DON, nursing conducted a review of all residents on pain medication to ensure appropriate availability and delivery of pain medications is taking place. Corrections were made as required.<br>Nurses will be in-serviced on 1-4-17 on ordering medications including narcotics and e-kit use to ensure that medications, including narcotics are properly ordered so they are always available for residents with orders for them. This training will include steps to be taken for various pain medication scenarios, including resident refusing pain medications on hand, increased narcotic usage and preventing a rapid depletion of any back-up narcotic. The evening nurse manager will audit narcotic supplies routinely on Mondays | |

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| F 309 | Continued From page 29<br>R42's Care Area Assessment (CAA) for pain indicated R42 had almost constant moderate pain that limited her day-to-day activity. The CAA indicated R42 was alert, oriented and able to request pain medications.<br><br>R42's care plan last revised 7/10/16, indicated R42 was at risk for impaired comfort with a goal of having discomfort less than daily. Interventions included administering medications as ordered for pain.<br><br>R42's physician's orders dated 12/1/16, identified orders for oxycodone (a short acting narcotic analgesic) 5 milligram (mg) tablets by mouth every four hours as needed (PRN) for pain related to chronic pain syndrome. The physician's orders also identified Fentanyl (a narcotic) pain patch 25 micrograms every 72 hours topically, as well as gabapentin (a medication used to treat nerve pain) 400 mg by mouth three times daily for chronic pain syndrome.<br><br>R42's pain interview assessment dated 9/23/16, indicated R42 experienced pain almost constantly which was moderate in intensity. The pain assessment indicated R42 rated the pain as a four out of ten (10 being the most severe pain), and indicated R42 indicated a 4 was tolerable.<br><br>R42's medication administration record (MAR) dated 11/16 indicated R42 had received oxycodone 5 mg tablets a total of 14 times during the month of November 2016 for pain levels ranging from a ten to a five on a ten-point scale. The November 2016 MAR indicated R42 had not received any oxycodone from 11/14/16 to 11/16/16. Documentation on the MAR indicated R42 had received as needed doses of | F 309 | and Thursdays to ensure that an adequate supply of narcotics is on hand and that all re-orders have current scripts on file at the pharmacy. Unit managers and the DON will be advised when the narcotic supply is low.<br>The Director of Nursing or her designee will audit back-up narcotic supplies for sufficiency weekly x 4 and then monthly thereafter. The DON or designee will report monthly to the QA Committee. | |

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| F 309 | Continued From page 30 acetaminophen 1000 mg on November 15, 16 and 17, 2016. R42's pain level listed for an acetaminophen dose given at 9:56 a.m. on 11/15/16, was identified as a 6. At 10:01 p.m., R42 had received another 1000 mg of acetaminophen for pain ranked at a 7. On 11/16/16, at 4:30 a.m. R42 rated her pain at a level 5 and received an additional 1000 mg of acetaminophen. At 5:43 a.m. on 11/17/16, R42 rated her discomfort at a ten. A nursing progress note dated 11/17/16 at 5:45 a.m., indicated R42 had been calling out and crying "Burning from nerves." The note further indicated the resident had orders for oxycodone however, the medication had run out and had been reordered from the pharmacy. The progress note indicated the resident continued to cry out and had been given PRN Tylenol 1000 mg at 5:45 a.m.<br><br>Even though R42 experienced discomfort and required as needed acetaminophen, documented follow up notes on the medication administration recored (MAR) indicated "E" (for effective) after each dose of acetaminophen R42 had received.<br><br>R42's narcotic log sheets for the months of October and November 2016 identified R49's prn oxycodone supply had run out at 1:45 p.m. on 11/13/16, and a new supply card was not checked in until four days later on 11/17/16, with the first dose administered from the card at 8:08 p.m. on 11/17/16.<br><br>During interview on 11/28/16, at 6:13 p.m. R42 stated she had experienced severe pain for three days when she did not have her oxycodone. R42 stated she thought they were out of the narcotic due to the doctor needed to send a new script to the pharmacy for the medication and then R42 | F 309 | | |

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remembered this was taken care of in November 2016. R42 stated no one had offered her oxycodone from the facility's emergency narcotic supply. When asked how severe her pain level had gotten, R42 stated "Oh, my [expletive] it was a nine!" The nine was based on a 1 to 10 pain scale and 9 bing excrutiating. R42 said the oxycodone helped manage the nerve pain she experienced in her hands.

During a follow-up interview on 11/30/16, at 3:51 p.m. R42 clarified her pain had been an 11 (worse than excruciating) during the time period when she had not received the oxycodone (between 11/13 and 11/17/16).

The director of nursing (DON) was interviewed on 11/30/16 at 4:32 p.m., she stated she was aware R42 had run out of her oxycodone around 11/13/16, and confirmed she would have expected staff to call the doctor on call to be able to provide coverage from their emergency kit supply. The DON stated she was unsure about the facility's policy related to procuring emergency supplies of medication from the pharmacy. She stated registered nurse (RN)-B would be the best person to ask about this situation.

During interview with licensed practical nurse (LPN)-B on 12/1/16 at 8:05 a.m., LPN-B stated the procedure to get emergency narcotics from the pharmacy included calling the pharmacy and getting authorization to take a medication from the emergency kit. LPN-B indicated sometimes staff had difficulty procuring re-order supply of narcotics from the pharmacy when the pharmacy needed a new script.

During interview on 12/1/16, at 8:44 a.m. LPN-A

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| F 309 | Continued From page 32<br>stated she recalled R42 running out of oxycodone on 11/13/16. LPN-A stated she had pulled the medication label to re-order the medication a few days before it ran out. LPN-A also stated she had faxed the pharmacy for more supply which never came in due to the pharmacy requiring a renewed script for the medication. LPN-A stated staff did not realize for a while that the pharmacy required a new prescription. She said they had then faxed R42's physician for the new prescription and during the time R42 was waiting for her oxycodone, LPN-A recalled offering gabapentin and the acetaminophen which she said R42 had expressed was effective.<br><br>During interview on 12/1/16 at 10:09 a.m., RN-B confirmed R42 had run out of oxycodone for several days between 11/13/16 and 11/17/16. RN-B said the medication renewal was faxed to the pharmacy but never came, and that staff sometimes had trouble getting medication when the prescriptions ran out.<br><br>During interview on 12/1/16 at 12:51 p.m., the consultant pharmacist (CP) stated staff at the facility should have called the pharmacy or on-call physician to get an emergency supply of oxycodone when R42 was having pain, as it was available in their e-kit (emergency kit).<br><br>A facility policy, untitled and undated included: "the pharmacy shall provide any pharmacy product needed on an emergency basis as promptly as is reasonably practicable. In the event pharmacy cannot furnish a pharmacy product ordered on an emergency basis in a reasonably prompt manner, pharmacy shall use its best efforts to determine whether another pharmacy provider is capable of providing such | F 309 | | |

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| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET CANNON FALLS, MN 55009 |

| (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 |
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| F 309 | Continued From page 33 pharmacy product to facility more promptly than pharmacy." | F 309 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure oral hygiene and grooming needs (hair combed) were provided for 1 of 3 residents (R42) reviewed who were dependent upon staff assistance with activities of daily living (ADL).<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified a diagnosis of paraplegia. R42's annual Minimum Data Set (MDS), dated 9/23/16 indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The MDS also identified R42 required extensive assistance of two staff for grooming activities.<br><br>R42's care area assessment (CAA) for activities of daily living (ADLs) printed 12/1/16, indicated R42 was totally dependent upon staff for all ADL's and was alert/oriented. Proceed to care plan to maintain current level of functioning.<br><br>R42's care plan dated 12/1/16, indicated R42 required assistance of one staff member to set up supplies and assist her for oral care and assistance of one staff in all other areas of | F 312 | Resident #42 has a new ADL program in place which includes oral care and grooming; this is being provided daily.<br>A new policy on oral care and ADL grooming has been developed. Residents have been reviewed to ensure that they are receiving appropriate ADL care, grooming, and oral care.<br>Nursing staff – nurses and NARs – will be re-trained on the elements of proper oral care for residents, ADL care, and grooming. Return demonstrations will be required to ensure adequate compliance with training.<br>A new resident dignity program has been developed which involves reviewing resident care daily to ensure that grooming has been done properly, hair combed, fingernails cleaned, proper bathing, and oral care. A form created as a checklist will be used to evaluate residents daily.<br>Unit managers or their designees will audit weekly x 4 and then monthly thereafter to ensure that the resident dignity review is being done daily; this will include on the spot observation of 10% of | 1/10/17 |

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| F 312 | Continued From page 34 hygiene.<br><br>During interview on 11/28/16, at 5:42 p.m. R42 stated she was trying to use dry shampoo on her hair and did not always even get her hair brushed on a daily basis.<br><br>During observation of morning cares on 12/1/16, at 10:13 a.m. nursing assistant (NA)-A and NA-B washed their hands and applied gloves, uncovered R42's upper body and proceeded to cleanse R42's skin folds and underarms, applying powder beneath the folds. NA-A and NA-B uncovered R42's lower body, cleaning underneath the skin folds of the abdomen and perineal area, rolled R42 on her side and cleansed her perineal area. After removing their gloves and disposing of the soiled linens into a plastic bag, licensed practical nurse (LPN)-A proceeded to provide wound care to R42's pressure ulcer, removing the soiled wound dressing materials, irrigating the wound with an antibacterial solution, cleansing her hands and proceeding to pack the wound with new dressing change materials. NA-A and NA-B completed a.m. cares after LPN-A finished dressing change. NA-A and NA-B proceeded to roll R42 onto her side and placed a magnetic wound therapy device beneath R42 and cover her up with her bed linen. LPN-A turned the magnetic device on and exited the room. NA-A and NA-B proceeded to remove their gloves and wash their hands, and exited the room without offering R42 her oral care materials nor offering to brush her hair or giving her the brush to complete it independently.<br><br>During interview on 12/1/16, at 11:13 a.m. R42 stated she would have liked to brush her hair and teeth after morning cares, "That would be kind of | F 312 | residents on random days of the week and a thorough review of the Resident Dignity Checklist to ensure that all items are being managed properly. After reviewing, the Unit Managers will deliver the checklists to the DON.<br>The Director of Nursing will report monthly to the QA Committee on this program. | |

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| F 312 | Continued From page 35<br>normal, wouldn't it?"<br><br>During interview on 12/1/16, at 11:24 a.m. registered nurse (RN)-B stated she would have expected staff to offer R42 her grooming materials to brush her hair as well as her oral care supplies with morning cares.<br><br>A policy related to activities of daily living and grooming was requested, none was provided. | F 312 | | |
| F 318 SS=D | 483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>(c) Mobility.<br><br>(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure range of motion (ROM) exercises were performed as recommended by the physical therapist (PT) for 1 of 2 residents (R42) reviewed for ROM and who had limited ROM.<br><br>Findings include:<br><br>R42's face sheet, dated 12/1/16 identified a diagnosis of paraplegia. R42's annual Minimum | F 318 | Resident #42 has a new system in place to ensure physical therapy will be performed as ordered by the physician. Other residents receiving physical therapy or functional maintenance have had their programs reviewed and a system installed to ensure that they are receiving their therapy. This system is the same as that explained below, designed to correct the deficiency.<br>Nursing and therapy staff have been | 1/10/17 |

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| F 318 | Continued From page 36 | F 318 | | |

Data Set (MDS) assessment dated 9/23/16, indicated a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). The MDS also identified R42 required extensive to total assistance with activities of daily living and had impairments in range of motion to both lower extremities.

R42's care area assessment (CAA) for ROM printed 12/1/16, indicated R42 was totally dependent upon staff for transfers and was only able to be out of bed one hour daily due to a pressure ulcer. The CAA identified R42 had little to no voluntary movement in the bilateral lower extremities, was extensively dependent on staff in all ADLs and was alert and oriented. Proceed to care plan to maintain current level of functioning.

R42's care plan dated 12/1/16, indicated R42 had limited range of motion to the left hand secondary to paraplegia and non-use. The care plan identified R42 had multiple restorative programs in place but exhibited non-compliance and nearly daily refusals. No program was listed for lower extremity range of motion on the care plan.

R42's functional maintenance program recommendations, dated 8/19/16 indicated staff to perform passive range of motion (PROM) bilateral foot, ankle, knees and hip internal/external rotation and hip abduction/adduction x 10 [repetitions] each. Program in binder hanging on closet, initial calendar when completed. To be done 3 x/week (Sunday, Tuesday, Friday).

R42's nursing progress notes for 8/2016 - 11/2016 reflected one entry related to range of motion services, recorded on 11/17/16 at 1:38

trained on a new method to ensure that residents receive their therapy as ordered by the physician. A calendar has been created and designated solely for resident therapy. Each unit has a copy, each unit manager, the therapy department, and the Director of Nursing. Each week, at the IDT meeting, the IDT will review the therapy calendar to ensure that resident therapies are listed there. Each shift, physical therapy and nursing check the calendar and mark off once therapy is completed. This is done for each resident to ensure that their therapy is completed.
The DON or her designee will do a weekly audit of the resident therapy calendar to ensure compliance. The head of therapy will also do his/her own weekly audit to ensure follow-through on the part of her staff.
The DON and head of therapy will report monthly to the QA Committee on this program.

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| F 318 | Continued From page 37 | F 318 | | |

p.m. The entry indicated the exercises were unable to be performed due to unable to lift [R42's] leg.

During interview on 11/18/16, at 5:43 p.m. R42 stated she was not receiving her range of motion to her lower extremities. A functional maintenance program instruction sheet, dated 8/19/16 was taped to the front of her closet next to a calendar for staff to initial the ROM exercises labeled 9/16. No initials were signed off on the calendar and R42 stated the last time she had received the exercises was in 8/2016.

During interview on 11/30/16, at 11:31 a.m. the activities director (AD) stated that she used to be the restorative aide, however that position was eliminated and now she was assigned activities. The position had not been replaced to her knowledge and she was unsure who was doing exercises now; and the restorative/functional maintenance program participation was usually documented in Point of Care.

During interview on 12/1/16, at 8:44 a.m. licensed practical nurse (LPN)-A stated she did not perform ROM to R42's legs because she could not lift them.

During interview on 12/1/16, at 9:51 a.m. the physical therapist (PT) indicated R42 would be a credible reporter of whether or not her functional maintenance program was getting done. "She is a strong advocate for herself, if she says it is not getting done she is a reliable reporter." The PT stated the restorative aide position had been eliminated the previous summer and had not been replaced to her knowledge. The PT stated she initiated the program due to R42 having

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trouble keeping her legs on her footrests in the wheelchair, and since R42 was not able to get up, the functional maintenance programming was very important to prevent further contractures of the lower extremities. The PT went to R42's room and performed an assessment of R42's lower ROM at this time, lifting R42's legs to perform ROM. The PT stated R42 had lost approximately five degrees of dorsiflexion in both of her feet and had increased tone and was "tight" in both legs, but had no new contractures.

When interviewed on 12/1/16, at 11:24 a.m. the registered nurse (RN)-B stated R42's lower extremity ROM was not performed because R42 was "Too heavy," and also due to R42 refusing the program.

During interview on 2/1/16, at 11:23 a.m. the director of nursing (DON) stated she was not sure why R42's restorative program for her lower extremities was not being implemented and that RN-B would be the best person to question about the lack of implementation.

Restorative program documentation was requested for R42 from Point of Care, none was provided.

The facility policy entitled Range of Motion Exercises, undated indicated the date and time the exercises were performed, name of the individual who performed the procedure, type of range of motion exercise given, whether the exercise was passive or active, length of the exercise and how the resident participated in the procedure, problems or complaints made by the resident and resident refusals should be documented in the medical record.

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| F 334 SS=E | 483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS | F 334 | | 1/10/17 |

(d) Influenza and pneumococcal immunizations

(1) Influenza. The facility must develop policies and procedures to ensure that-

(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal

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| F 334 | Continued From page 40<br>immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br><br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br><br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br><br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br><br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to implement the Center for Disease Control and Prevention (CDC) guidelines related to pneumococcal conjugate vaccine (PCV13) for 7 of 9 residents (R12, R1, R63, R24, R39, R29, R60) whose vaccination histories were reviewed.<br><br>Findings include:<br><br>Center for Disease Control and Prevention (CDC) identified, "Adults 65 years of age or older who | F 334 | Nursing Dept. will, upon admission, determine whether residents have received either of the pneumococcal vaccines, and retrieve dates of administration if able. Vaccinations will be recorded in the residents record as historical, and will state whether the vaccine received was PCV 23 or PCV13. If either vaccine cannot be documented, one or both vaccines as appropriate, will be offered and documented in the | |

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| F 334 | Continued From page 41<br>have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose."<br><br>R12's immunization record dated 12/1/16, indicated the 71 year old had received a pneumococcal vaccination on 3/7/2007, however, it did not indicate which vaccine was given. The current immunization record provided on 12/1/16, failed to indicate subsequent dosing of the pneumococcal vaccine was offered to R12 as recommended by CDC guidelines.<br><br>R1's immunization record, dated 12/1/16, indicated the 69 year old had received a pneumococcal vaccination on 7/1/2007, however, it did not indicate which vaccine was given. The current immunization record provided on 12/1/16, failed to indicate subsequent dosing of pneumococcal vaccine was offered to R1 as recommended by CDC guidelines.<br><br>R63's immunization record, dated 12/1/16, indicated the 74 year old had received a pneumococcal vaccination on 4/10/09, however it did not indicate which vaccine was given. The current immunization record provided failed to indicate subsequent dosing of pneumococcal vaccine was offered to R63 as recommended by CDC guidelines.<br><br>R24's immunization record, dated 12/1/16, indicated the 73 year old had received a pneumococcal vaccination on 1/1/13, however it did not indicate which vaccine was given.<br>The current immunization record provided failed | F 334 | residents records. Residents R63, R1, R12,R24, R39 and R60 will be offered PCV 23 by 1/10/2017 if not contraindicated, and offered PCV 13 by 2/10/2018. Licensed nurses will be educated at the Nursing Meeting on 1/4/2017 regarding recording which vaccine to record and that both vaccines must be offered and documented. MDS Coordinator will monitor vaccination status with each MDS Assessment completed (at least quarterly) and will update DON and Nurse Manager when vaccinations are missing from a resident's immunization record.<br><br>Completion date 1-10-2017<br>Monitored by MDS, Nurse Managers | |

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to indicate subsequent dosing of pneumococcal vaccine was offered as recommended by CDC guidelines.

R39's immunization record, dated 12/1/16, indicated the 99 year old had received a pneumococcal vaccination on 7/2/15, however it did not indicate which vaccine was given.
The current immunization record provided failed to indicate subsequent dosing of pneumococcal vaccine was offered as recommended by CDC guidelines.

R29's immunization record, dated 12/1/16, indicated the 75 year old had received a pneumococcal vaccination on 10/25/10, however it did not indicate which vaccine was given.
The current immunization record provided failed to indicate subsequent dosing of pneumococcal vaccine was offered as recommended by CDC guidelines.

R60's immunization record, dated 12/1/16, indicated the 71 year old had received a pneumococcal vaccination on 9/26/15, however it did not indicate which vaccine was given.
The current immunization record provided failed to indicate subsequent dosing of pneumococcal vaccine was offered as recommended by CDC guidelines.

When interviewed on 12/1/16, at 12:52 p.m. the director of nursing (DON) indicated she was not aware of the current CDC guidelines related to the pneumococcal vaccinations. The DON confirmed resident's had not been evaluated for the a second pneumococcal vaccine per the CDC guidelines. The DON stated she thought the vaccine was given every ten years.

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| F 334 | Continued From page 43<br><br>A review of the facility policy, titled Pneumococcal Vaccine for the Superior Healthcare Management Minnesota Region was received. The policy is undated and unsigned identified "All residents will be offered pneumococcal vaccines to aid in preventing pneumococcal infections. Number 7 of the policy indicated "Administration of the pneumococcal vaccines or revaccination's will be made in accordance with current Centers For Disease Control and Prevention (CDC) recommendations at the time of the vaccination." Number 8 of the policy indicated "Inquiries concerning our facility's policies governing pneumococcal vaccinations should be referred to the Infection Preventionist or Director of Nursing Services." | F 334 | | |
| F 412<br>SS=D | 483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS<br><br>(b) Nursing Facilities<br><br>The facility-<br><br>(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:<br><br>(i) Routine dental services (to the extent covered under the State plan); and<br><br>(ii) Emergency dental services;<br><br>(b)(2) Must, if necessary or if requested, assist the resident-<br><br>(i) In making appointments; and | F 412 | | 1/10/17 |

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| | 245304 | A. BUILDING ______ B. WING ______ | 12/01/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET CANNON FALLS, MN 55009** |

| (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 412 | Continued From page 44<br><br>(ii) By arranging for transportation to and from the dental services locations;<br><br>(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide dental services for 1 of 3 residents (R72) reviewed who required routine dental services.<br><br>Findings include:<br><br>R72 had been observed and interview on 11/29/16, at 2:30 p.m. R72 was noted to have several darkened chipped and missing teeth throughout his mouth. R72 indicated he had bad teeth that included missing, chipped and decayed teeth due to his long time substance abuse of methamphetamine. R72 further included it was hard to chew, but indicated he would rather chew regular textured food than to adjust the texture. R72 stated he did not have problems with swallowing. R72 further included he had not been seen by a dentist for many years and would like to have his teeth examined, because they hurt at times.<br><br>Review of R72's admission Minimum Data Set (MDS) assessment dated 8/18/16, identified the resident as having no problems with his oral cavity and did not include R72's chipped, missing or decayed teeth. Review of the most recent quarterly MDS assessment dated 11/4/16, identified that R72 had no mouth pain, swallowing | F 412 | DSM will address oral status, MDS coordinator will double check DSM assessment for completion or oral status in Dietary Assessment with each MDS Assessment (at least quarterly). R72 to be seen by In-House dentist on 1/3/2017. Ongoing dental care schedule is maintained by In-House Services per agreement. R72's care plan has been updated.<br>All residents will be seen by in-house dental after signing the in-house service agreement, or will be encouraged to see an outside dentist if they choose not to utilize in-house services as evidenced by signed consent forms in resident records. Social worker will document decline of in-house services, and will monitor dental appointments and will update In-House Services monthly with new residents who have chosen to use In-House Dental Services.<br>Completion date 1-10-2017<br>Monitored by MDS Coordinator and Social Services | |

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| F 412 | Continued From page 45 or eating problems; R72's weight has been stable at 185 pounds and brushes his own teeth after set-up assistance.<br><br>Review of the most current dietary assessment for R72 dated 11/1/16, indicated the resident is on a regular diet and eats 50 percent of his meals. Weight is stable at 185 pounds . No problems with swallowing. The assessment did not include the condition of the residents teeth.<br><br>Review of R72 's oral data collection tool dated 11/1/16, identified the residents oral cavity as having no problems other than missing teeth, but refused to allow staff to complete the exam.<br><br>Review of R72's current plan of care identifies the resident as being independent with eating after set- up and receives a regular diet. Interventions: eats independently after set up assistance and obtain, record and monitor weights and fluids. R72 eats 50 percent of his meals. The care plan further indicated R72 has natural teeth and brushes them independently. The care plan did not include nor address R72's chipped, missing or decayed teeth.<br><br>Interview with the facility social service director on 11/29/16, at 2:00 p.m. who monitors and schedules needed dental exams for the residents, indicated she was aware of R72's need and desire for dental services but failed to have him seen by the on site dentist. The on-site dentist conducted exams at the facility on 10/19/16. The social service director indicated a dental appointment had not been set up nor checked into as of this time for R72. | F 412 | | |
| F 441 | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, | F 441 | | 12/27/16 |

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| F 441 SS=F | Continued From page 46<br>PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, | F 441 | | |

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| F 441 | Continued From page 47<br>depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to implement a comprehensive infection control program which included consistent tracking, trending and analysis of illnesses and infections to prevent potential spread to others. This had potential to affect all 56 residents, staff and visitors to the facility.<br><br>Findings include:<br><br>A binder was provided by registered nurse (RN)-A | F 441 | The Director of Nursing and Infection Control Nurse will implement a tracking log on each unit to track antimicrobial administration, lab cultures and diseases to improve the infection control correlation by 1/1/2017. Nursing will obtain results of cultures which have been sent to lab for analysis and report results on the tracking log beginning 1/1/2017. A monthly tracking log will be maintained in the office of the infection control nurse beginning | |

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| F 441 | Continued From page 48<br>the infection control nurse on 12/1/16, at 12:35 p.m. with different tabbed sections representing each specific month of infection control monitoring. The following information was identified:<br><br>February 2016:<br><br>An order listing report identified nine different residents who had received antibiotics during the month for different diagnoses which included cellulitis, pneumonia and urinary tract infections (UTI). The report lacked room numbers, consistent documentation of organism, or if the infection was determined to be community or in-house acquired.<br><br>The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.<br><br>There was no further provided information.<br><br>March 2016:<br><br>An order listing report identified 14 residents had received antibiotics or other medication during the month for different diagnoses which included urinary tract infection (UTI), skin, bronchitis and yeast. The report lacked room numbers, organism cultures or if the infection was determined to be community or in-house acquired.<br><br>Seven of the fourteen residents had UTI. A resident was treated with Cipro 250 mg by mouth twice daily from 3/8-3/14/16. The urine culture revealed no growth or an organism identified. | F 441 | the month of January, 2017; compliance will be monitored through the use of the monthly tracking log. The evening Nurse manger will review the unit logs weekly for completion, copy and give to the infection control nurse beginning 1/1/2017. Staff nurses will be educated on procedure and review policy at the nursing meeting on 1/4/2017<br>Completion date 12-28-2016<br>Monitored by Director of Nursing and Infection Control Nurses | |

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| F 441 | Continued From page 49 | F 441 | | |

Another resident was treated with Levaquin 500 mg daily for 7 days for prophylaxis without an identified type of infection or culture results documented on the report. Another resident had "? infection" listed with not culture results documented on the report. This resident was treated with Levaquin 500 mg by mouth daily for 5 days.

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

April 2016:

An order listing report identified 12 infections where residents had received antibiotics during the month. Two of the 12 had sites of infection documented, the others were blank. The report lacked any room numbers, type of infection, any documentation of organism, consistent date of resolution or if the infection was determined to be community or in-house acquired.

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

May 2016:

An order listing report identified 15 infections where residents had received antibiotics during the month. Three of the 15 had sites of infection

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|---|---|---|---|---|
| F 441 | Continued From page 50 | F 441 | | |

Continued From page 50

documented, the others were blank. The report lacked any room numbers, type of infection, any documentation of organism, consistent date of resolution or if the infection was determined to be community or in-house acquired.

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

June 2016:

An order listing report identified 18 infections where residents had received antibiotics. There were documented sites of infection and more detail related to the use of Bactroban, and Nystatin. The report lacked consistent date of resolution or if the infection was determined to be community or in-house acquired.

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

July 2016:

An order listing report identified 6 infections where residents had received antibiotics. There were no documented sites of infection. The report lacked  room numbers, type of infection, any documentation of organism, consistent date of resolution or if the infection was determined to be community or in-house acquired.

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| F 441 | Continued From page 51 | F 441 | | |

The collected data lacked trending or analysis of the infections in the facility to determine the cause of each infection or if they had potential to or were spreading in the facility.

There was no further provided information.

August, September, October and November 2016:

No order listing report was provided.

When interviewed on 12/1/16, at 12:52 p.m. the director of nursing (DON) confirmed the past four month of reports didn't exist. When asked about an antibiotic stewardship program, the DON was not aware of it and had not implemented anything related to antibiotic reeducation. Further, the DON stated the infection control program lacked consistent monitoring, trending or analysis of the collected data, adding "We have to enhance our program."

During the interview, the DON stated infections were discussed at their Monday through Friday clinical rounds but there was not any processes for tracking or trending.

Infection Control policy was requested but not received.

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

F5304024

PRINTED: 01/04/2017
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245304 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **11/29/2016** |

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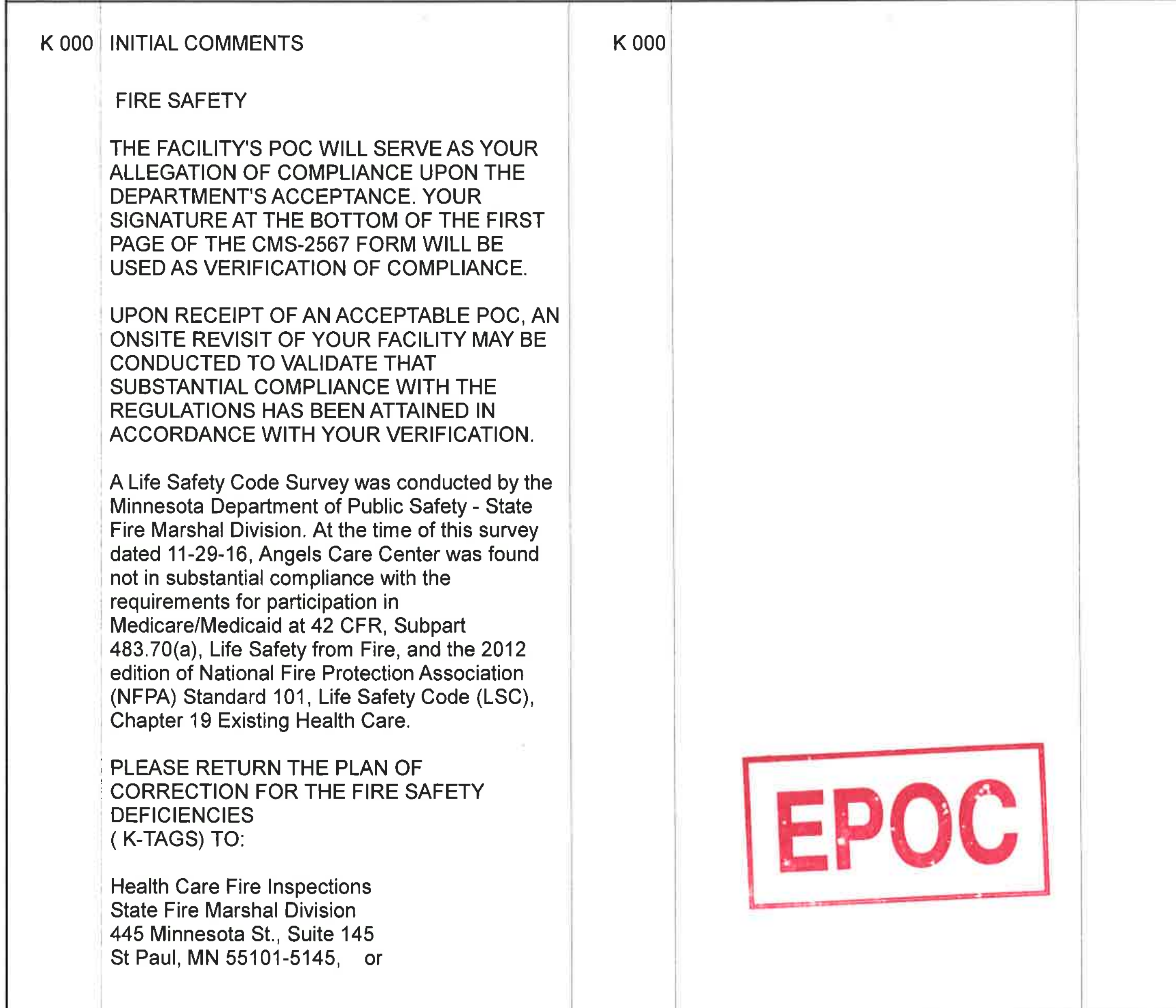
|---|---|
| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET**<br>**CANNON FALLS, MN 55009** |



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| K 000 | INITIAL COMMENTS | K 000 | | |

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 11-29-16, Angels Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
( K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE

(X6) DATE: 12/27/2016

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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|---|---|---|---|
| | 245304 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 11/29/2016 |

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| K 000 | Continued From page 1<br>By email to:<br>Marian.Whitney@state.mn.us and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>This facility will be surveyed as one building. The Gardens at Cannon Falls Former (Angels Care Center) is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1977 and was determined to be of Type II(111) construction. In 1982, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1985, another addition was added to the South Wing and was determined to be Type II (111). In 2007 the chapel was added and was determined to be Type V (111) with a 2 hour separation.<br><br>The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 73 beds and had a census of 64 at the time of the survey. | K 000 | | |

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| K 000 | Continued From page 2<br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 351<br>SS=D | NFPA 101 Sprinkler System - Installation<br><br>Spinkler System - Installation<br>2012 EXISTING<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br>This STANDARD is not met as evidenced by:<br>Spinkler System - Installation<br>2012 EXISTING<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of | K 351 | Filled opening as identified in survey with appropriate flame retardant material. Will monitor future projects where penetrations are made for running cables and lines.<br><br>Completion 12-26-2016<br>Monitored by Maint. Director | 12/27/16 |

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| | 245304 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING | **11/29/2016** |

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|---|---|---|---|---|
| K 351 | Continued From page 3<br>Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br><br>On facility tour between 09:00 AM and 01:00 PM on 11/29/16, based on observation and interview revealed or based on documentation review and interview that the findings include:<br>1. A large opening around the dryer vent pipe was observed in the laundry room.<br><br>This deficient practice could affect the safety of all the residents, staff and visitors within the compartment.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 351 | | |
| K 363<br>SS=D | NFPA 101 Corridor - Doors<br><br>Corridor - Doors<br>2012 EXISTING<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates | K 363 | | 12/27/16 |

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|---|---|---|---|
| | 245304 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 11/29/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET<br>CANNON FALLS, MN 55009 |

| (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 |
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| K 363 | Continued From page 4<br>of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted.<br>Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This STANDARD is not met as evidenced by:<br>Corridor - Doors<br>2012 EXISTING<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted.<br>Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire | K 363 | All Fire doors were checked and corrected so they positively latch when closed. Will check on a monthly basis to ensure ongoing compliance and log kept to track.<br>Completed on 12-26-2016<br>Monitored by Maint. Director | |

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|---|---|---|---|
| | 245304 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 11/29/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET<br>CANNON FALLS, MN 55009 |

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|---|---|---|---|---|
| K 363 | Continued From page 5<br>window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices,<br><br>On facility tour between 09:00 AM and 01:00 PM on 11/29/16, based on observation and interview revealed or based on documentation review and interview that the findings include:<br>1. It was observed that the fire separation doors for the Chapel would not positively latch into the frame.<br><br>This deficient practice could affect the safety of all the residents, staff and visitors within the compartment.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 363 | | |
| K 372<br>SS=D | NFPA 101 Subdivision of Building Spaces - Smoke Barrie<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system | K 372 | | 12/27/16 |

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|---|---|---|---|
| | 245304 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **11/29/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET**<br>**CANNON FALLS, MN 55009** |

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| K 372 | Continued From page 6<br>in REMARKS.<br>This STANDARD is not met as evidenced by:<br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br><br>On facility tour between 09:00 AM and 01:00 PM on 11/29/16, based on observation and on documentation review and interview that the findings include:<br>1.Penetrations were found in the NE walls around office 202 for the 200 wing.<br><br>This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 372 | Penetration was filled with appropriate fire resistive material.<br>Completed 12-26-2016<br>Monitored by Maint. Director | |
| K 374<br>SS=D | NFPA 101 Subdivision of Building Spaces - Smoke Barrie<br><br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective | K 374 | | 12/27/16 |

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| | 245304 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 11/29/2016 |

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| THE GARDENS AT CANNON FALLS | 300 NORTH DOW STREET<br>CANNON FALLS, MN 55009 |

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| K 374 | Continued From page 7<br>plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>This STANDARD is not met as evidenced by:<br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br><br>On facility tour between 09:00 AM and 01:00 PM on 11/29/16, based on observation and interview revealed or based on documentation review and interview that the findings include:<br>1.It was observed that the smoke barrier doors for the 100 wing would not positively latch into the frame.<br><br>This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of | K 374 | All fire doors were checked and corrected so they positively latch when closed. Will check on a monthly basis to ensure ongoing compliance and log kept to track<br>Completed on 12-26-2016<br>Monitored by Maint. Director | |

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|---|---|---|---|
| | 245304 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **11/29/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **THE GARDENS AT CANNON FALLS** | **300 NORTH DOW STREET**<br>**CANNON FALLS, MN 55009** |

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|---|---|---|---|---|
| K 374 | Continued From page 8<br>discovery. | K 374 | | |
| K 920<br>SS=D | NFPA 101 Electrical Equipment - Power Cords and Extens<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This STANDARD is not met as evidenced by:<br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for | K 920 | 6 way adapter was removed from outlet, power strip with reset replaced it. All managers and Maint. Director will monitor building for compliance<br>Completed 12-26-2016<br>Monitored by staff and Maint. Director | 12/27/16 |

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|---|---|---|---|---|
| K 920 | Continued From page 9<br>PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>On facility tour between 09:00 AM and 01:00 PM on 11/29/16, based on observation and interview revealed or based on documentation review and interview that the findings include:<br>1.Observations revealed the improper use of a power strip in the kitchen office. A 6 way outlet adapter was being used on the wall outlet and a power strip was plug into adapter.<br><br>This deficient practice could affect the safety of all the residents, staff and visitors within the compartment.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 920 | | |