DEPARTMENT OF HEAI	TH AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDI	CAID SERVICES	
	MEDICA	ARE/MEDICAL	D CERTIFIC	ATION A	AND TRANSMITTAL		ID: 2C84	
	PART I -	TO BE COMPI	LETED BY T	HE STAT	TE SURVEY AGENCY		Facility ID: 00758	
1. MEDICARE/MEDICAID PROV NO.(L1) <b>245304</b>	IDER	3. NAME AND AI (L3) <b>THE GARD</b>	ENS AT CANN	NON FALI	LS	4. TYPE OF ACTI	ON: <u>7</u> (L8) 2. Recertification	
2. STATE VENDOR OR MEDICA (L2) <b>847972200</b>	ID NO.	(L4) 300 NORTH (L5) CANNON F.		T	(L6) <b>55009</b>	3. Termination 5. Validation 7. On-Site Visit	4. CHOW 6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE C (L9) 12/20/2013	OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey Afte		
<ol> <li>6. DATE OF SURVEY</li> <li>8. ACCREDITATION STATUS:</li> </ol>	<b>2/27/2017</b> <sup>(L34)</sup> (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR END	ING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Othe	r	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICAT From (a): To (b):	ION	0		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN		Services Limit	
12.Total Facility Beds	<b>74</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code		om Size	
13.Total Certified Beds	<b>74</b> (L17)		npliance with Prog and/or Applied W		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY MEETS			
18 SNF 18/19 SN	IF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	EMARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Marietta Lee, HFE	NE II	0	04/06/2017	(L19)	Kamala Fiske-Downing	, Enforcement Spe	cialist 04/06/2017 (L20)	
P	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	STATE AGENCY	· · · · ·	
19. DETERMINATION OF ELIGI 1. Facility is Eligible t	to Participate		IPLIANCE WITH HTS ACT:	I CIVIL	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
2. Facility is not Eligi	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION <b>02/01/1986</b>	BEGINNINC	5 DATE	ENDING DAT	Έ	VOLUNTARY     00       01-Merger, Closure		<u>NTARY</u> Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	n of Admissions:	(1.44)		04-Other Reason for Withdrawal	07-Provid 00-Active	der Status Change	
(L27)	B. Rescind Su	spension Date:	(L44)			00-2 101 10	-	
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		00270						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



#### 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,

Kumalu 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.

The Gardens At Cannon Falls March 22, 2017 Page 2

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.

The Gardens At Cannon Falls March 22, 2017 Page 3 Feel free to contact me if you have questions.

Sincerely,

Kumalu Piske Downing

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: <u>Kamala.Fiske-Downing@state.mn.us</u>

## **POST-CERTIFICATION REVISIT REPORT**

				DATE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building				
245304 <sub>Y1</sub>	B. Wing	Y2	2	2/27/2017	Y3
			L		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GARDENS AT CANNON F	ALLS	300 NORTH DOW STREET			
		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).

ITE		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0253	Correction	ID Prefix	F0318		Correction	ID Prefix	F0334		Correction
Reg. #	483.10(i)(2)	Completed	Reg. #	483.25	(c)(2)(3)	Completed	Reg. #	483.80(d)(1)(2)		Completed
LSC		02/15/2017	LSC			02/15/2017	LSC			02/15/2017
ID Prefix	F0441	Correction	ID Prefix	F0520		Correction	ID Prefix			Correction
Reg. #	483.80(a)(1)(2)	(4)(e)(f) Completed	Reg. #	483.75 (h)(i)	(g)(1)(i)-(iii)(2)(i)(ii)	Completed	Reg. #			Completed
LSC		02/15/2017	LSC			02/15/2017	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEWE		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
		GPN/kfd	3/13/20	17			15425			7/2017
REVIEWE CMS RO		REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/1/2016					ANY UNCORRECTED DEFICIENCIE				I YE	s 🗌 no

DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDIC	CAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL		ID: 2C84
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00758
1. MEDICARE/MEDICAID PROV NO.(L1) 245304	IDER	3. NAME AND AL (L3) <b>THE GARD</b>	ENS AT CAN	NON FALI	LS	4. TYPE OF ACTIO	$\frac{7^{(L8)}}{\mathbf{2. Recertification}}$
2. STATE VENDOR OR MEDICA (L2) 847972200	ID NO.	(L4) 300 NORTH (L5) CANNON FA		ET	(L6) <b>55009</b>	3. Termination 5. Validation	4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE O (L9) <b>12/20/2013</b>	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Afte	
<ol> <li>6. DATE OF SURVEY 01</li> <li>8. ACCREDITATION STATUS:</li> </ol>	/ <b>19/2017</b> <sup>(L34)</sup>	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 0 15 ASC	FISCAL YEAR ENDI	NG DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	r	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATI	ION	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requirem	ents:
To (b):		0	equirements		2. Technical Personnel	6. Scope of Se	ervices Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Di	rector
12 Total Essility Pads	74 (118)		cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Roo	m Size
12.Total Facility Beds	74 (L18)	X			5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	<b>74</b> (L17)		npliance with Prog and/or Applied V	-	* Code: B	(L12)	
14. LTC CERTIFIED BED BREAKI	DOWN				15. FACILITY MEETS		
18 SNF 18/19 SN	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
74							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY RE	MARKS (II' AFFLICA			DAIL).			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Sarah Strenke, HF	E NE II	0	4/05/2017	(L19)	Kamala Fiske-Downing	, Enforcement Spec	cialist 04/05/2017 (L20)
P	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIE	BILITY		IPLIANCE WITH ITS ACT:	H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr	ancial Solvency (HCFA-257 ol Interest Disclosure Stmt	
1. Facility is Eligible to	o Participate	RIOI	IISACI.		3. Both of the Abov		(IICIA-1515)
2. Facility is not Eligi	ble (L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	[:	(L30)
OF PARTICIPATION <b>02/01/1986</b>	BEGINNINC	<b>DATE</b>	ENDING DA	ГЕ	VOLUNTARY         00           01-Merger, Closure         0		<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provid	er Status Change
(L27)	D Dessind C	Deter	(L44)			00-Active	
	B. Rescind Si	spension Date:	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00270					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



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 Gardens At Cannon Falls January 26, 2017 Page 2

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 <u>Email: gary.nederhoff@state.mn.us</u> 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 Gardens At Cannon Falls January 26, 2017 Page 4

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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

The Gardens At Cannon Falls January 26, 2017 Page 5 dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

The Gardens At Cannon Falls January 26, 2017 Page 6

Kumalu Fiske Downing

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				PPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-	<u>O</u>	<u>MB NO. C</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE S COMPL	LETED
		245304	B. WING		R 01/10	9/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/13	5/2017
THE GAF	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ſS	{F 00	00}		
	completed on Janu certification tags the found on the CMS2 were not found corr	ification revisit (PCR) was ary 17, 18, & 19, 2017. The at were corrected can be 567B. Also there are tags that rected at the time of onsite ated on the CMS2567.				
		complaint H5304036 which had at F309 is now found				
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as liance.				
{F 253} SS=E	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility will be conducted to antial compliance with the en attained in accordance with EKEEPING & MAINTENANCE	{F 25	53}	2	2/15/17
	necessary to maint comfortable interior This REQUIREMEN by: Based on observat failed to maintain a and resident rooms staff and visitors. T all 61 residents in th Findings include:	NT is not met as evidenced tion and interview, the facility clean, sanitary environment, in good repair, for residents, his had the potential to affect he facility.		A review has been done by the maintenance director throughout the facility to observe for any other prob similar to those cited under this tag corrections are being made as requ Facility staff have been trained on the facility corrections under this citation	blems ; uired. he n and	
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		
Electron	ically Signed				0	2/03/2017

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.

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
			A. BUILDI	NG		3
		245304	B. WING			י 19/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		13/2017
THE GAP	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OF CON (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
{F 253}	Continued From pa	ge 1	{F 25	3}		
	on 1/18/17, at 9:03 On the 100 wing: There were two win 121. On the 200 wing: Torn wall paper in h and 211, and 225 a wallboard below; st stained carpet at 20 front of room 228 w room 221 bathroom around toilet and ve room 227 with miss On the 300 wing: Broken window blin licensed practical n the tour; strong urin hallway; lower edge between dining rooi paint and plaster; s activities closet doo During interview at	g the initial environment tour a.m., revealed the following: dow blinds broken in room allway between rooms 209 nd 227, revealing the rong urine odor in hallway; 00 wing desk; hallway carpet in ith a 12 inch stain on carpet; n-brown stained linoleum ery strong urine odor; and ing blind towards head of bed. d in room 309, verified by urse (LPN)-B at the time of the odor in throughout the tes of both sides of archway m and living room-missing cratches on full width of r, located in the dining room. that time, LPN-B stated not the scratches had been there.		to report any problems base physical plant to maintenan. They have been trained on through the maintenance pr the units. Corrections have been mad based on the citations: "Room 121 Two broken repaired "Rooms 209 211 and 3 Walls paper rips have been between these rooms in the "Urine odor in 200 hallwa corrected by addressing the is in the rooms. "200 hall stained carpo station cleaned "Room 221, new flooring bathroom "Room 221 urine smell of "Room 309 blinds fixed "300 wing: Strong urine a eradicated "Lower edges of archwa dining room and living room fixed scratches and paint "300 Wing activities doo	ce for repair. reporting oblem log on le as followed window blinds 225  227 repaired hallway ay has been source which et at nurse s g put down in corrected ds replaced smell y between on 300 wing ing	
	Two main dining rooms had broken ceiling tiles. 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			fixed " (2) ceiling tiles in main of are fixed Audit: The facility ED will re- corrections to the physical p ensure that the corrections and any similar problems ar managed in a timely manner maintenance department. T	view blant and in this citation re being er by the	

Facility ID: 00758

If continuation sheet Page 2 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES		APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245304	B. WING _				R 19/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	UI/	10/2017
THE GAE	RDENS AT CANNON F	ALLS			00 NORTH DOW STREET		
				C	ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 253}	Continued From pa on activities closet of	-	{F 25	53}			
	p.m., the hall smelle worse in the summe "nose blind" to it. Th	nterview on 1/18/17 at 2:00 ed of strong urine and it is er. After a while you become ne air conditioning doesn't nmer and the urine smell is					
	director (ED) on 1/1 observations were were maintenance common three wings and at a to write needed rep 300 wing archway r closet door scratche paper between roor three inch tear. ED	tal tour with environmental 8/17, at 3:00 p.m., the above verified. ED stated there was a nunication book on each of the front lobby desk, for staff airs. ED verified not aware of missing plaster and activity es. ED identified the torn wall ms 225 and 227, as about verified the torn wallpaper and 211 had been repaired					
{F 318} SS=D	Although a policy fo was requested, non 483.25(c)(2)(3) INC DECREASE IN RAI	REASE/PREVENT	{F 31	18}			2/15/17
	(c) Mobility.						
	receives appropriate	imited range of motion e treatment and services to notion and/or to prevent further of motion.					
	appropriate service	imited mobility receives s, equipment, and assistance ove mobility with the maximum					

Facility ID: 00758

If continuation sheet Page 3 of 18

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:		IG	СОМ	PLETED
					F	7
		245304	B. WING _			19/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DΕ	
THE GAP	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
{F 318}	Continued From pa	ge 3	{F 318	3}		
	mobility is demonst	idence unless a reduction in rably unavoidable. NT is not met as evidenced				
	Based on observat review, the facility fa motion (ROM) exer recommended by th of 3 residents (R13 Findings include: R13 diagnosis foun dated January 2017 (MS), Type 2 diabet polyneuropathy and weakness. R13's treatment addi indicate any ROM s R13's aide care flow indicates R13 to rec program to include bilateral lower extre each joint one time foot buckets on whe indicating this was of (1/15/17) for the mo R13's progress note 1/19/17 does not im exercises or reasor ROM. R13's Care Area As dated 4/11/16, indic multiple sclerosis (N with his activities of requires two staff for dressing. R13 trans non ambulatory and	wsheet dated January 2017 ceive functional nursing passive range of motion to emities X 10 repetitions to daily. Position feet back in eelchair. Review of form done 1 out of 19 days		ROM has been set up and is performed for Residents #13 a Floor nurse and nurse manag compliance with ROM program review checklist, perform rand observations for compliance, managers will document in the records weekly. A review has been done to en any other resident at the facili ordered to have ROM is gettir Nursing staff will be trained by ensuring ROM exercises are of physician ordered and on the ROM policy. They will also be the new ROM calendar explai A new ROM calendar explai A new ROM calendar has bee and the IDT updated this with exercises for residents based physician orders. This calenda available to PT and Nursing s be followed daily. The DON of designee (in conjunction with that the calendar is updated e morning in the morning meeti delivered to the units. During f ROM is provided, staff memb the completed ROM exercises the name of the resident listed calendar. The policy on ROM updated to reflect the use of th calendar.	and #42. er, to ensure ms, will dom ROM and nurse e residents' sure that ty who is ng ROM. 2-3-17 on done as per updated trained on ned below. en developed ROM on ar is made o that it can r her PT) ensures very mg and the day, as ers cross off s based on d on the will be his ROM	

Facility ID: 00758

		& MEDICAID SERVICES				0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED		
		245304	B. WING			۲ ۱۹/2017		
	PROVIDER OR SUPPLIER	245504		STREET ADDRESS, CITY, STATE, ZIP CODE	01/	19/2017		
				300 NORTH DOW STREET				
THE GAI	RDENS AT CANNON I	FALLS	CANNON FALLS, MN 55009					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE		
{F 318}	assessment period R13's quarterly Min 12/8/16, indicates F 15/15 indicating no Interview on 1/18/1 stated he had not r for a long time and perform any ROM of extremities. Interview on 1/18/1 director of admissio verified R13 was on program and was to from the nursing as Observation of mon 7:18 a.m. until 7:38 (NA)-A, ROM exerce R13. Interview on 1/19/1 stated he doesn't c was unaware he ne as the nurse if he s Interview on 1/19/1 practical nurse (LP ROM exercises con R13 usually refuses the refusals are doo unaware of where t be documented. Interview on 1/19/1 therapist assistant assistants were res exercises daily for	ough it was present during this imum Data Set (MDS) dated R13 to have a BIMS score of cognitive impairment. 7, at 2:10 p.m. with R13. R13 eceived ROM therapy services when asked stated staff never exercises to his lower 7, at 2:27 p.m. with the ons and staff development, n a functional maintenance o receive ROM one time daily sistants. ming cares on 1/19/17, from 8 a.m. with nursing assistant cises were not completed for 7, at 7:53 a.m. with NA-A omplete ROM for R13 and eeded to. NA-A said her would should be doing ROM for R13. 7, at 7:54 a.m. with licensed N)-A stated R13 should have mpleted daily. LPN-A stated s ROM and when asked where cumented stated she was the refusals were and should 7, at 10:02 a.m. with physical (PTA) verified the nursing sponsible to complete ROM	{F 318]		alendar d. The			

Facility ID: 00758

If continuation sheet Page 5 of 18

		AND HUMAN SERVICES			FORM	02/07/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245304	B. WING			R <b>19/2017</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GA	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 318}	ensure that ROM e for residents. Policy titled, "Range undated and missin purpose of this proor resident's joints and identify when ROM completed, who sho should perform exe R42's face sheet, d diagnosis of paraple Data Set (MDS) as indicated a Brief Int (BIMS) score of 15 also identified R42 assistance with acti impairments in range extremities. R42's care area as indicated R42 was for transfers and wa one hour daily due identified R42 had I in the bilateral lowe dependent on staff oriented. Proceed current level of funct R42's care plan dat limited range of mo to paraplegia and n identified R42 had r in place but exhibite daily refusals. No p	xercises are being completed e of Motion Exercises" ng pages identifies, "the cedure is to exercise the d muscles". Policy does not exercises should be ould receive services or who ercises. lated 1/19/17, identified a egia. R42's annual Minimum sessment dated 9/23/16, terview for Mental Status (cognitively intact). The MDS required extensive to total ivities of daily living and had ge of motion to both lower sessment (CAA) for ROM totally dependent upon staff as only able to be out of bed to a pressure ulcer. The CAA little to no voluntary movement r extremities, was extensively in all ADLs and was alert and to care plan to maintain	{F 318}			

Facility ID: 00758

If continuation sheet Page 6 of 18

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	02/07/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245304	B. WING			R <b>19/2017</b>
NAME OF	PROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GA	RDENS AT CANNON F	FALLS		00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 318}	Nursing assistant (I observed providing 1/19/17, at 10:40 a. stated that they car passive rang of mo provided to R42 du time R42 stated 10 range of motion to I A copy of the treatm (TAR) for the month reviewed. On page with a start date of [passive range of m knees and hip inter abduction 10 times stretching x 30 sect hanging on closet, completed. To be d Sunday, Tuesday a The treatment adm R42 completed 4 o January 2017. The 11, 12, 13, and 15, The calendar hangi to enter the room is calendar was blank indicated PROM ha A copy of the calent requested but not m Trained medication interviewed on 1/19 PROM for R42. TM	NA)-D and NA-E was morning cares for R42 on .m. NA-D and NA-E both nnot recall the last time tion (PROM) had been te to lack of time. At the same t42 a.m. she had not had her legs since August of 2016. Inent administration record h of January 2017 was 4 of 10 the following treatment 8/20/16, "perform PROM notion] bilateral foot, ankle, rnal/external rotation and hip each with gentle HC onds. Program in binder initial calendar when lone 3 times per seek on and Friday, in the morning." tinistration record had ROM for ut of 19 opportunities in re was check mark on January 2017. ing on the back of R42's door s from September 2016. The k, no initials from staff that ad been done.				

If continuation sheet Page 7 of 18

DEPART	FORM	APPROVED					
		& MEDICAID SERVICES				OMB NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
			A. DOILL				R
		245304	B. WING				19/2017
NAME OF F	PROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAP	RDENS AT CANNON F	FALLS					
				(	CANNON FALLS, MN 55009		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
			1		,		
{F 318}	Continued From pa	ae 7	{F 3	18}	L		
	•	5	(	)			
		sistant (PTA)-A was					
		/17, at 10:06 a.m. PTA-A worked with R42 for over a					
		Function Maintenance					
	Program (FMP) in p	blace which is to be done by					
	nursing.						
	PTA-B was interviev	wed on 1/19/17, at 12:04 p.m.					
	PTA-B indicated the	ere was no request to evaluate					
		bast month. PTA-B stated R42					
	8/2016.	by physical therapy since					
		aintenance program					
		dated 8/19/16 indicated staff range of motion (PROM)					
	bilateral foot, ankle,						
	internal/external rot						
		n x 10 repetitions each side. in binder hanging on the back					
		om had directions to use					
	calendar when com	pleted. PROM to be done 3					
	x/week on Sunday,	Tuesday, Friday.					
	The facility policy er	ntitled Range of Motion					
	Exercises, undated	indicated the date and time					
		performed, name of the					
		ormed the procedure, type of ercise given, whether the					
		ve or active, length of the					
	exercise and how the	he resident participated in the					
		is or complaints made by the nt refusals should be					
	documented in the						
		e Officer (CEO) was					
		1/17, at 11:31 a.m. as the was not available during this					

If continuation sheet Page 8 of 18

	-	AND HUMAN SERVICES			FORM	02/07/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245304	B. WING			R 19/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAR	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 318} {F 334} SS=E	post certification rev unable to locate aud R42 as it was issue exited 12/1/16. The correction should has the PROM services 483.80(d)(1)(2) INF PNEUMOCOCCAL (d) Influenza and pr (1) Influenza. The fa and procedures to a (i) Before offering th each resident or the receives education potential side effect (ii) Each resident is immunization Octob annually, unless the contraindicated or t immunized during th (iii) The resident or has the opportunity (iv) The resident's r documentation that following: (A) That the resider	view (PCR). The CEO was dits related to the PROM for ed on the recertification survey CEO stated the plan of ave been in place related to a for residents. CLUENZA AND IMMUNIZATIONS neumococcal immunizations acility must develop policies ensure that- ne influenza immunization, e resident's representative regarding the benefits and is of the immunization; offered an influenza per 1 through March 31 e immunization is medically he resident has already been his time period; the resident's representative to refuse immunization; and medical record includes indicates, at a minimum, the	{F 318	}		2/15/17
	(B) That the resider	nt either received the influenza				

If continuation sheet Page 9 of 18

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (		E SURVEY PLETED
			A. DOILDI	nu.		F	3
		245304	B. WING				19/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAR	RDENS AT CANNON F	ALLS		-	00 NORTH DOW STREET		
	· · · · · · · · · · · · · · · · · · ·			С	ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
{F 334}	Continued From pa	-	{F 33	34}			
		l not receive the influenza o medical contraindications or					
		disease. The facility must d procedures to ensure that-					
	representative rece	ne pneumococcal resident or the resident's ives education regarding the ial side effects of the					
	immunization, unles	offered a pneumococcal as the immunization is icated or the resident has nized;					
		the resident's representative to refuse immunization; and					
		nedical record includes indicates, at a minimum, the					
	was provided educa	nt or resident's representative ation regarding the benefits ffects of pneumococcal					
	pneumococcal imm the pneumococcal i contraindication or	nt either received the Junization or did not receive Immunization due to medical refusal. NT is not met as evidenced					
	Based on interview facility failed to impl	and document review, the ement the Center for Disease tion (CDC) guidelines related			Residents #106 and #108 had had t PCV13 offered to them and administ as required.		

Facility ID: 00758

If continuation sheet Page 10 of 18

STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	0938-039 SURVEY PLETED
		245304	B. WING _			F 01/1	२ ∣ <b>9/2017</b>
NAME OF I	PROVIDER OR SUPPLIER			STF	-		
THE GAI	RDENS AT CANNON	FALLS			NORTH DOW STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
{F 334}	to pneumococcal of 2 of 3 residents (F histories were revise Findings include: Center for Disease identified, "Adults 6 have not previously have previously rec PPSV23 [pneumoc 23] should receive PCV13 should be g receipt of the most R106, 75 years old 1/13/17, according Admitting Nurse Pa Collection form, pa page one, 9b. idem there was no date Pneumonia Vaccin undated, included, the past. We would you remember whe years ago verbally Although the form f the vaccine. The or provided on 1/18/1 pneumococcal vac pneumococcal vac	onjugate vaccine (PCV13) for 106, R108) whose vaccination	{F 33		A review was done for any other rein the facility who has not had the vaccination offered and/or administed corrections were made accord Nurses have been trained on the nupdated policy written from the CD policy on the pneumococcal vaccir particularly about offering the vacci and administration Under a new program designed to that residents receive the new conpresent of the right to accept or refuse a rulist of residents will be kept by the and the infection control nurse. This will also consist of a column to be checked-off when the vaccinations been offered, rejected, or accepted date, name of person administering well as name of the vaccination. The will be reviewed weekly by the infecontrol nurse and the DON together verify that the new policy is being kept up to date. The ED wireport quarterly to the QA Committ this program.	tered lingly. ew, C aations, inations ensure jugate t least nning DON is list have d, the g, as his list ction er to tept. the list ill	
		, was admitted to the facility to facility Nursing Admission					

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	02/07/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245304	B. WING			R 19/2017
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GA	RDENS AT CANNON I	FALLS		00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 334}	Admitting Nurse Pa Collection form, pa page one, 9b. ident there was no date of Pneumonia Vaccine undated, included: in the past. We wo Do you remember @ Mayo-forgets." A education about pn included risk and bo identify if R108 war immunization recor to identify date of p identify type of pnet to indicate if R108 vaccine administer Document review of Pneumococcal Vac Adults, Including G undated. Procedur assess adults for n and PPSV23, scree precautions, provid statements, prepar document vaccinat medical emergenci to federal vaccine a system. During interview on of staff developmer pneumococcal vaca	art 1/Day 1 Version 1.4, Data ge one. Review of same form, tified pneumovax although entered. Review of facility e Informed Consent Form "I have received the vaccine buld like to update our records. when? Date received: Rec'd Although the form included neumovax 23 vaccine and enefits, the form failed to nted the vaccine. The current rd provided on 1/18/17, failed neumococcal vaccine, failed to umococcal vaccine, and failed wanted the pneumovax 23 ed. of facility Administering ccines (PCV13 and PPSV23) to eriatric Residents policy re for Vaccination included: eed of vaccination of PCV13 en for contraindications and le vaccine information e to administer vaccines, ion, prepare to manage tes, report all adverse events adverse event reporting	{F 334}			

If continuation sheet Page 12 of 18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	·		IPLETED R
		245304	B. WING				n 19/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAR	RDENS AT CANNON F	ALLS			800 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 334} {F 441}	vaccine, type of pne failed to indicate if pneumovax 23 vacc 483.80(a)(1)(2)(4)(6	acked date of pneumococcal eumococcal vaccine, and R106 and R108 wanted the cine administered. e)(f) INFECTION CONTROL,	{F 3: {F 4-				2/15/17
SS=F	PREVENT SPREA	D, LINENS tion and control program.					
	The facility must es	tablish an infection prevention n (IPCP) that must include, at					
	investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin	l upon the facility assessment ig to §483.70(e) and following tandards (facility assessment					
		ds, policies, and procedures ich must include, but are not					
	possible communic	eillance designed to identify able diseases or infections ead to other persons in the					
		om possible incidents of ase or infections should be					
		ansmission-based precautions event spread of infections;					

If continuation sheet Page 13 of 18

	IMENT OF HEALTH							FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO	JPPLIER/CLIA			CONSTRUCTION		(X3) DATE COMI	E SURVEY PLETED
		245	304	B. WING _					२ <b>।9/2017</b>
NAME OF F	PROVIDER OR SUPPLIER	•			STR	EET ADDRESS, CITY,	, STATE, ZIP CODE		
THE GAP	RDENS AT CANNON I	FALLS				NORTH DOW STRE			
(X4) ID PREFIX TAG		ATEMENT OF DEFICI Y MUST BE PRECED SC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	(	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 441}	Continued From pa	ige 13		{F 44	1}				
	(iv) When and how resident; including l								
	<ul> <li>(A) The type and dudepending upon the involved, and</li> <li>(B) A requirement t least restrictive positive circumstances.</li> </ul>	nt or organism should be the							
	<ul> <li>(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</li> </ul>								
	(vi) The hand hygie by staff involved in								
	(4) A system for rec under the facility's I actions taken by the	PCP and the co							
	(e) Linens. Person process, and transpread of infection.	oort linens so as							
	(f) Annual review. annual review of its program, as necess This REQUIREMED	IPCP and upda sary.	ate their						
	by: Based on interview facility failed to imp infection control pro consistent tracking illnesses and infect spread to others. T	lement a comprogram which in trending and a ions to prevent	rehensive cluded nalysis of potential		E e r	DON and Infection ensure that no ne resulted from the control program.	been reviewed by on Control nurse to egative effects hav deficient infection	) /e 	
FORM CMS-25	567(02-99) Previous Versions	•	Event ID:2C8412	2		/ ID: 00758			Page 14 of 18

		AND HUMAN SERVICES				APPROVE 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМ	E SURVEY PLETED	
		245304	B. WING			R 19/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
THE GAI	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE	
{F 441}	Continued From pa	-	{F 44	41}			
	61 residents, staff a	and visitors to the facility.		elements of the new infection of program and the infection con-			
	Findings include:			has received assistance and the the I-CAR program on develop	aining from		
	for January 2017, v infection control nu	a.m., the infection control log vas requested from the rse (ICN)-A. The ICN-A stated		managing a successful infection program. The DON will also re training.	on control ceive this		
	completed because due to an illness. T	6 infection control log was not e she was off work for ten days he ICN-A provided a list of		Based on the I-CAR review an which will take place the week 2/11/2017, a new infection con	of trol		
	antibiotics that were 2016 and January 2	e prescribed for December 2017.		program has been developed includes: 1. Consistent tracking of infe			
	"Monthly Infection (	05 p.m., the ICN-A provided a Control Log. The Monthly og from the 100 Wing (a		treatment 2. Trending and analysis of il infections			
	information today.	CN-A stated she compiled the The ICN-A was asked about		<ol> <li>Proper reporting to nursing are advised on the nature and of infections in the facility.</li> </ol>	treatment		
	related to infections indicated it is done	o compile and analyze data s in the facility. The ICN-A at the end of each month vs.		<ol> <li>Development of monthly in control log</li> <li>Tracking for organisms an</li> </ol>			
		t the month to address prevent the spread and		treatment The DON will do an audit weel then monthly thereafter to ens infection control nurse is prope	ure that the		
	The Monthly Infection Control Log provided for Wing 100 (TCU) dated 12/16-1-17, revealed the following: The "date of onset" of the infection form was missing for 11 residents listed.			developing and maintaining the control program including the t trending logs. DON and Infect	e infection racking and ion Control		
				will meet weekly to review log completion and cross reference and symptoms of infections to documentation is completed in	ing of signs ensure		
	The "organism(s)/d 14 residents listed.	late cultured" was missing for		residents' records. Staff nurse document residents' temperate signs and symptoms of infectio	s will ures and		
	The "date infection residents listed.	resolved" was missing for nine		noting symptoms and contacti provider for clinical indicators a medication orders; with antibic	ng the and		

Facility ID: 00758

If continuation sheet Page 15 of 18

	-	AND HUMAN SERVICES			FORM	: 02/07/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245304	B. WING _			R 19/2017
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 441}	Wing 200 and Win provided by the ICI The ICN-A was inte p.m. indicated a lis antibiotics prescrib by the nurse mana stated the lists did antibiotics that wer The ICN-A stated t completed until the that is when the ph prescribed antibioti The ICN-A stated t employee illnesses not aware tracking necessary. Also the the possible need t related to an outbre	ion Control Log requested for g 300 was requested and not N-A. erviewed on 1/19/17, at 1:27 t of residents who had ed for the month was provided ger on each wing. ICN-A not include all infections or e prescribed. he infection logs are not e end of the month because harmacy provided a list of ics that were used. he facility did not track s. The ICN-A stated she was employee infections was e ICN-A would not be aware of to confine a resident or wing eak of resident illness or if pe needed if patterns of	{F 44	1} administration; and for 5 days after antibiotic completion. The Infection Control nurse or the DON will rep quarterly to the QA Committee on program.	n ort	
F 520 SS=F	interview during the A request was mac policy but not recei 483.75(g)(1)(i)-(iii)( COMMITTEE-MEN QUARTERLY/PLA (g) Quality assess (1) A facility must m	de for the infection control ived. (2)(i)(ii)(h)(i) QAA //BERS//MEET	F 52	20		2/15/17

Facility ID: 00758

If continuation sheet Page 16 of 18

		AND HUMAN SERVICES				FORM	APPROVED
							0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	( - )	E SURVEY PLETED
						F	7
		245304	B. WING			01/	19/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAR	RDENS AT CANNON F	ALLS			00 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIZ TAG	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 500			u 				
F 520		ge 16	F 5	20			
	minimum of:						
	(i) The director of n	ursing services;					
	(ii) The Medical Dire	ector or his/her designee;					
	(iii) At least three ot	her members of the facility's					
	staff, at least one of						
	administrator, owne individual in a leade	er, a board member or other ership role; and					
	(g)(2) The quality as committee must :	ssessment and assurance					
	coordinate and eval identifying issues w	arterly and as needed to luate activities such as ith respect to which quality ssurance activities are					
		plement appropriate plans of entified quality deficiencies;					
	Secretary may not r records of such con such disclosure is r	formation. A State or the require disclosure of the nmittee except in so far as elated to the compliance of h the requirements of this					
	committee to identif deficiencies will not sanctions. This REQUIREMEN	faith attempts by the fy and correct quality be used as a basis for NT is not met as evidenced					
	facility failed to ensu	v and document review, the ure the Quality Assurance and A) effectively sustained			The facility has a QA Committee a administration has reviewed it to er that it meets the standards required	isure	

Facility ID: 00758

If continuation sheet Page 17 of 18

STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		245304	B. WING		R 01/19/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• • • • •
THE GA	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLÉTIO
F 520	form past surveys i immunization, rang updating care plans and environmental identified during the (PCR) exited 1/19/- effect all 61 resider Findings include: See F253 Houseke Services. See F318 Increase of Motion See F334 Influenza Immunizations See F441 Infection Interview on 1/19/1 administrator, verifi meets quarterly and including the directed director. Administra committee discussed identified quality de committee at their I had not discussed previously cited def they had recently b quality indicators in	Ige 17 e related to repeat citations n regards to pneumococcal e of motion services including s, infection control program concerns, which were e post certification resurvey 17. This had the potential to ots residing in the facility. reping and Maintenance /Prevent Decrease in Range a and Pneumococcal Control, Prevent Spread 7, at 2:19 p.m. with the ed the QA&A committee d includes department heads or of nursing and medical ator when asked if the QA&A es action plans to correct ficiencies responded, the ast meeting held on 1/18/17, the plan of correction or ficiencies. Administrator stated een focusing more on the cluding food quality. ssurance was not obtained	F 52	0 QA Committee including the app members, time frames for meetin the business of the committee w among other things, to keep qua assurance at an approved level, especially with regard to the citat received and corrected in the pre- surveys. Management staff has been re-th the importance of the QA Comm on ensuring that it fulfills its role of correcting facility deficiencies an maintaining those corrections. Th following will be presented at QA as part of facility action plans: Co of F253, F318, F334 and F441. A list of citations and programs of to correct them has been created QA Committee. Based on this lis Committee will review each prog quarterly in the QA Committee on course of the 2017 year to ensur compliance with the POC on each program. Where any variations a it will be the responsibility of the Committee to steer those progra on track through the responsible The chairperson for the QA Com will check-off when each program been discussed and whether it h approved as working properly du quarter or if follow-up is needed. The Facility ED will ensure that th Committee Program Checklist is completed and a copy delivered facility manager and member of Committee within (7) days of the QA Committee.	ng, and hich is, lity ions eceding rained on ittee and of d ne Meetings prrections eveloped d for the t, the QA ram ver the e th are found, QA ms back parties. mittee n has as been ring that the QA

Facility ID: 00758

If continuation sheet Page 18 of 18

## **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION A. Building		D	ATE OF REVIS	Т
	5				
245304 <sub>Y1</sub>	B. Wing	Y2	<u>,</u> 1/	/19/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GARDENS AT CANNON F	ALLS	300 NORTH DOW STREET			
		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).

ITE	Μ		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	483.10(j)(2)-(4)		Completed	Reg. #	483.10	(a)(1)	Completed	Reg. #	483.10(f)(1)-(3)		Completed
LSC			01/10/2017	LSC			01/10/2017	LSC			01/10/2017
ID Prefix	F0243		Correction	ID Prefix	F0278		Correction	ID Prefix	F0279		Correction
Reg. #	483.10(f)(5)(i)-(	iii)(6)(7)	Completed	Reg. #	483.20	(g)-(j)	Completed	Reg. #	483.20(d);483.21	(b)(1)	Completed
LSC			01/10/2017	LSC			01/10/2017	LSC			01/10/2017
ID Prefix	F0282		Correction	ID Prefix	F0285		Correction	ID Prefix	F0309		Correction
Reg. #	483.21(b)(3)(ii)		Completed	Reg. #	483.20	(e)(k)(1)-(4)	Completed	Reg. #	483.24, 483.25(k)	(I)	Completed
LSC			01/10/2017	LSC			01/10/2017	LSC			01/10/2017
ID Prefix	F0312		Correction	ID Prefix	F0412		Correction	ID Prefix			Correction
Reg. #	483.24(a)(2)		Completed	Reg. #	483.55	(b)(1)(2)(5)	Completed	Reg. #			Completed
LSC			01/10/2017	LSC			01/10/2017	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			
REVIEWI STATE AG		REVIEW (INITIAL		<b>DATE</b> 1/27/20	)17	SIGNATURE O	F SURVEYOR	37476		<b>DATE</b> 1/19/2	2017
REVIEW		REVIEW (INITIAL		DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/1/2016						ECTED DEFICIEN CIES (CMS-2567)				s 🗌 no	

## **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		[	DATE OF REVIS	IT	
	B. Wing	Y2	2 1	1/10/2017	Y3	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
THE GARDENS AT CANNON F	ALLS	300 NORTH DOW STREET				
		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).

ITE		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0351	12/27/2016	LSC H	<0363		12/27/2016	LSC	K0372		12/27/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #			Completed
LSC	K0374	12/27/2016		<0920		12/27/2016	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEW		REVIEWED BY (INITIALS) TL/kfd	<b>DATE</b> 1/27/201		SIGNATURE OF	SURVEYOR	37008		<b>DATE</b> 1/10/	2017
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 11/29/20		Y COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?							



#### 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

An equal opportunity employer.

The Gardens At Cannon Falls February 2, 2017 Page 2 deficient practice.

F243 will be removed from the Statement of Deficiencies.

### F309-S/S (G) 42 CFR §483.24, 483.25 (k)(I) 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

The Gardens At Cannon Falls February 2, 2017 Page 2 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

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		ľ		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-			. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245304	B. WING _		12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAP	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00		
F 166 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa regulations has beet your verification su complaint investigat the time of the stan An investigation of completed. This co F309. An investigation of completed during the substantiated. An investigation of completed during the substantiated. An investigation of completed during the substantiated. (j)(2) The resident he must make prompt	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with rvey was conducted and tion(s) were also completed at dard survey." complaints H5304036 were mplaint was substantiated at complaint H5304034 was he survey and found not to be complaint H5304033 was he survey and found not to be aft TO PROMPT EFFORTS EVANCES has the right to and the facility efforts by the facility to resolve dent may have, in accordance	F 16			1/10/17
		DER/SUPPLIER REPRESENTATIVE'S SIGI		TITLE		(X6) DATE
	ically 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.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 02/02/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	ATE SURVEY
		245304	B. WING _		12	2/01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
THE GAF	DENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 166	Continued From pa	ge 1	F 16	56		
		ust make information on how or complaint available to the				
	to ensure the prom regarding the reside paragraph. Upon re a copy of the grieva grievance policy mu (i) Notifying residen	t individually or through				
	facility of the right to (meaning spoken) of grievances anonym of the grievance off can be filed, that is, address (mailing ar number; a reasonal	ent locations throughout the offile grievances orally or in writing; the right to file lously; the contact information icial with whom a grievance his or her name, business and email) and business phone ble expected time frame for ew of the grievance; the right		<b>D</b>		
	to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvement Agency and State L	lecision regarding his or her contact information of s with whom grievances may pertinent State agency, nt Organization, State Survey ong-Term Care Ombudsman on and advocacy system;				
	responsible for ove receiving and tracki conclusions; leading by the facility; main information associa example, the identit	evance Official who is rseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all ted with grievances, for ty of the resident for those ed anonymously, issuing				

		AND HUMAN SERVICES				FORM	02/02/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	-	(X3) DATE	E SURVEY PLETED
		245304	B. WING	i		12/0	01/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
	RDENS AT CANNON F			300 NORTH DOW STREET			
		-ALLS		CANNON FALLS, MN 5	5009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIV CROSS-REFERENCE		BE	(X5) COMPLETION DATE
F 166	<ul> <li>coordinating with stanecessary in light of (iii) As necessary, tanecessary in light of (iii) As necessary, tanecessary, tanecessary in light of (iii) As necessary, tanecessary, tanecessary in light of (iii) As necessary, tanecessary in light of (iii) As necessary in light of (iii) As necessary, tanecessary in light of (iii) As necessary, tanecessary, tanecessary</li></ul>	ecisions to the resident; and cate and federal agencies as f specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately d violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and	F	166			
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID:2C8411		Facility ID: 00758	If continua	tion sheet	Page 3 of 50

	-	AND HUMAN SERVICES & MEDICAID SERVICES				APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	( )	E SURVEY PLETED
		245304	B. WING	·····	12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
THE GAP	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 166	3 years from the iss decision. This REQUIREMEN by: Based on interview facility failed to ens a complaint grievar electric razor for 1 of for missing persona Findings include: R34's quarterly Mini identified a Brief Int of 13 (cognitively in During interview on stated he had been about two weeks, a looking for it. Altho nursing assistant st him. During interview on social worker (SW)	Arrow of the grievance NT is not met as evidenced Arrow and document review, the ure follow-up investigation into ace in regards to missing of 2 residents (R34) reviewed al property. imum Data Set, dated 11/1/16 erview for Mental Status score tact). 11/28/16, at 5:25 p.m. R34 missing his electric razor for nd was not sure if staff were ugh he had reported it to a aff, no one had gotten back to 11/29/16, at 3:15 p.m. the -A stated there should be a	F 1	<ul> <li>R34's family has been notipurchasing a new razor for The facility has draited a new rocedure on the filing of g will present it to all resident upon admission. It will be pnext resident council meetiresidents' families will be m the new resident grievance forms. These forms are also in the admissions packets. will be tracked and monitor Families and residents will findings. This will be monitored by the Social Service and will be of 1-1-2017</li> </ul>	the resident. we policy and rievances and s and families presented at the ng. The nailed copies of and lost items to now included All grievances ed weekly. be notified of	
	SW-A further stated should fill them out lost something and provided the mission nine month period a	by missing resident items. If that nursing assistants if they are told a resident has it is not located. SW-A then by item reports for the previous at this time, consisting of only or of the reports were for R34's				
	registered nurse (R R34 was missing a	11/30/16, at 11:18 a.m. N)-B stated she was unaware razor. Any staff member who was missing should fill out a				

If continuation sheet Page 4 of 50

		AND HUMAN SERVICES			FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT			0938-0391 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245304	B. WING _		12/(	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•=/	
THE GAF	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET		
				CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	complaint form for t to social services. I for Veteran's Day an then.	he missing item and turn it in RN-B stated R34 was shaved nd would likely have had it	F 16	56		
	licensed practical n aware activities had ago and now it was	11/30/16, at 11:20 a.m. urse (LPN)-A stated she was I given R34 a razor a while missing, but could not state een informed it was gone.				
	activities director (A brand new razor he happened within the she had wanted to p however did not hav last time she went of stated it was on her	11/30/16, at 11:31 a.m. the D) stated R34 was missing a had gotten and that it had e last month. The AD stated burchase R34 a new one, we the funds in her budget the on a shopping trip. The AD list to purchase at a future not aware of any missing item the razor.	C			
F 241 SS=D	undated, stated res missing items must Nursing Services, a or mistreatment of r immediately investig	ntitled Lost and Found, ident or family complaints of be reported to the Director of and reports of misappropriation resident property are gated. TY AND RESPECT OF	F 24	11		1/10/17
	resident in a manner promotes maintena her quality of life red individuality. The fa- promote the rights of	t treat and care for each er and in an environment that nce or enhancement of his or cognizing each resident's cility must protect and of the resident. NT is not met as evidenced				

Facility ID: 00758

If continuation sheet Page 5 of 50

STATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
		245304	B. WING _		12/	01/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
THE GA	RDENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 241	Continued From pa	age 5	F 24	1		
	review, the facility environment for 1 for dignity whose u and catheter bag w uncovered in her m Findings include: R42's face sheet, of diagnoses of parag R42's annual Minir identified a Brief In of 15 (cognitively in During interview or stated she was not and dignity. R42 in catheter bag being incontinence produ- entering the room visualized at this ti her bed, uncoverent A box of gloves an sitting on top of he stated she rarely g pressure ulcer on a frequent reposition During observation R42's catheter bag draining into the bag was lying out on he During observation	dated 12/1/16 identified olegia and urinary retention. mum Data Set, dated 9/23/16 iterview for Mental Status score ntact). In 11/28/16, at 5:43 p.m. R42 t always treated with respect idicated she did not like her gleft uncovered and her ucts being left out for anyone to see. R42's catheter bag was me to be hanging on the end of d with urine present in the bag. d incontinence wipes was r bedside stand. R42 further iot out of bed due to having a her bottom that required her sourced with urine ag and an incontinence pad		Per resident request, Residen met with Social Worker, Nurse Ombudsman and DON to revie plan on 12/28/2016. The admission nurse will put o upon admission for patients wit to ensure catheter bag is cove shift and all residents /patients catheters will have order addee order portal on 12/21/2016. An audit will be developed and performed weekly by evening I Manager to ensure that inconti products, gloves, etc. are out of visitors/other residents and all bags are covered when cares being performed. Staff meeting on 1/4/2017 will include review dignity policy. This will be monitored by the N Managers and DON	Manager, ew care rder in PCC th catheters red every with d to PCC will be Nurse nence of view of catheter are not g minutes ing resident	

If continuation sheet Page 6 of 50

		AND HUMAN SERVICES				RINTED: FORM MB NO.	APPROV	ΈD
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		(X3) DATE	E SURVEY PLETED	
		245304	B. WING	i		12/0	01/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•		
THE GAR	RDENS AT CANNON F	FALLS		300 NORTH DOW STREE CANNON FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTIOI IVE ACTION SHOULD ED TO THE APPROPI FICIENCY)	BE	(X5) COMPLETIO DATE	ON
F 241	applying a clean go and providing incor Licensed practical r complete wound ca 10:54 a.m., R42's n and all staff exited l pad was lying on R- some gloves, and h exposed without a co of her bed. Dark an bag. During interview on stated it bothered h left out and incontin bedside stand, as s up herself. R42 stat her room would be she had bowel and not feel she should them up. During interview on nurse (RN)-B stated R42's catheter bag was out of the room RN-B confirmed tha left out was undigni During interview on director of nursing ( products should no but stated as long a face the hallway it r A facility policy was of daily living and p none was provided.	he top half of her body, then win and washing her lower half intinence care. At 10:37 a.m., nurse (LPN)-A proceeded to are on R42's pressure ulcer. At norning cares were completed R42's room. An incontinence 42's bedside stand along with her urinary catheter was cover on it, hanging at the end inber urine was present in the 12/01/16, at 11:13 a.m. R42 her that the catheter bag was hence supplies were on her she was unable to pick them ted anyone who stopped by able to see them and know bladder issues, and she did have to remind staff to pick 12/1/16, at 11:24 registered d she would have expected be covered whenever she h, but not necessarily in bed. at incontinence products being ified. 2/1/16, at 11:23 a.m. the (DON) stated that incontinence t be left out in resident rooms, as a urinary catheter bag didn't might be okay.		241				
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID:2C8411		Facility ID: 00758	If continua	tion sheet	Page 7 o	f 50

		AND HUMAN SERVICES			FORM	: 02/02/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	E SURVEY IPLETED
		245304	B. WING		12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
THE GAP	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 242 SS=D	483.10(f)(1)-(3) SE RIGHT TO MAKE (	LF-DETERMINATION - CHOICES	F 2	42		1/10/17
	schedules (includin health care and pro- consistent with his of and plan of care an of this part. (f)(2) The resident H about aspects of his are significant to the (f)(3) The resident H members of the con community activitie facility. This REQUIREMEN	has a right to choose activities, g sleeping and waking times), widers of health care services or her interests, assessments, d other applicable provisions has a right to make choices s or her life in the facility that e resident. has a right to interact with mmunity and participate in s both inside and outside the NT is not met as evidenced	C			
	facility failed to ens R11) reviewed for c according to their p frequency. Findings include: R42's face sheet, d	and document review, the ure 2 of 3 residents (R42 & choices received baths references for bathing ated 12/1/16 identified a legia and urinary retention.		Admission assessment update include questions of preference bath/shower, time (day/evenin weekly bath /shower. Extra we bath/showers can be accomm based on staff scheduling. Re bath/shower schedule by DON Managers monthly to ensure of of bath schedule on Kardex ar plan.	e of g) for eekly odated view of I/Nurse onsistency	
	9/23/16 indicated a Status (BIMS) score R42's care area as of daily living (ADL) R42 was totally dep and was alert and c	num Data Set (MDS), dated Brief Interview for Mental e of 15 (cognitively intact). sessment (CAA) for activities , printed 12/1/16 indicated bendent upon staff in all ADL priented. Proceed to care plan level of functioning.		Nurse meeting agenda on 1/4/ included education of docume bath/shower body audit and re Nurse Manager to conduct we on Refusal to ensure body aud completed and documentation given and or refused. Bath au assessment updated to include documentation of bath/shower	nting fusals. ekly audits lits are of baths dit e nurse	

Facility ID: 00758

If continuation sheet Page 8 of 50

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			Pi		APPROVED
CENTEF	RS FOR MEDICARE	& MEDICAID SERVICES			OI		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				( - )	E SURVEY PLETED
		245304	B. WING _			12/0	01/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	DENS AT CANNON F	ALLS			0 NORTH DOW STREET		
		/		C/	ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	Continued From pa	ge 8	F 24	42			
	required assistance	ted 12/1/16 indicated R42 of two staff for bathing and d bath weekly and as needed			refused.		
		ssion assessment, dated ify how often R42 preferred a					
	stated she was not preferences and ha she would like a bai was "not encourage to use dry shampoo	11/28/16, at 5:42 p.m. R42 bathed according to her d not been asked how often th, and receiving extra baths ed." R42 stated she was trying o on her hair and did not r hair brushed on a daily basis.	C				
	a.m. R42 stated she times per week if po aware it took a lot o stated she thought	erview on 12/1/16, at 10:12 e would like a bath a couple of ossible, however she was f time for the staff. R42 she was told this would be an point during her stay.					
	2:30 p.m. the social residents were asket their admission nurs documentation of st form.	12/1/16, at approximately worker (SW)-A indicated all ed about bathing frequency on sing assessment, any uch should be included on this view on 11/30/16, at 11:38					
	bath for the past 2 w thought the staff we during these times. would like a bath at	dicated she had not had a weeks. R11 included she ere too busy to give her a bath R11 further included she least weekly. nt quarterly Minimum Data					

		AND HUMAN SERVICES					FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		ISTRUCTION			0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,					PLETED
		245304	B. WING _				12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIF	• CODE		
THE GAF	RDENS AT CANNON F	ALLS			RTH DOW STREET ON FALLS, MN 55009			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	CANT	PROVIDER'S PLAN OF C		J	(¥5)
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		(EACH CORRECTIVE ACTION	ON SHOULD	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SCIDENTIFTING INFORMATION)	TAG		CROSS-REFERENCED TO TH DEFICIENCY			Ditte
			1					
F 242	Continued From pa	ge 9	F 24	42				
		0/28/16, indicated R11's						
		ur during this assessment s 1 assistance with bathing.						
		interview for mental status						
		out of 15 (meaning cognition						
	is intact).							
	Review of the most	current plan of care for R11,						
	identifies the reside	nt as having an activities of						
		e deficit related to being easily ecrease, history of falls,						
		and atrophy. Interventions;						
	requires 2 assistant	ce with bathing, washing and						
	transfers. Staff to w	ash hair and do nail care.						
	Review of the week	ly bathing sheets for the past						
	month, indicated R <sup>-</sup>	11 received a bath on						
		nd 11/12/16, but did not the weeks of 11/19/16 or		•				
	11/26/16.	life weeks of 11/19/10 of						
		acility MDS coordinator on						
		n.m. confirmed R11 did not						
	assessment period	dated 10/28/16. The MDS						
		luded that she had not not						
	a bath during this til	ny the resident did not receive						
	Ū							
		tered nurse (RN)-B a nurse						
		16, at 1:35 a.m. confirmed nentation that R11 had						
	received a bath in the	he past 2 weeks. She also						
		in checks during bathing had						
	not been completed	as well.						
	Interview with nursi	ng assistants (NA)-C, NA-D						
		(16, at 1:43 p.m. indicated they						
	were primary careg	ivers for R11's wing and						

If continuation sheet Page 10 of 50

STATEMENT OF DERICENCES       (X) PERDIMPERIATION NUMBER:       (X) MULTIPLE CONSTRUCTION       (X) DUELY CONSTRUCTION			AND HUMAN SERVICES			FORM	: 02/02/2017 APPROVED . 0938-0391	
NAME OF PROVIDER OF SUPPLIER     STREET ADDRESS, CTV, STATE, ZP CODE       THE GARDENS AT CANNON FALLS       STREET ADDRESS, CTV, STATE, ZP CODE       SUMMARY STATEMENT OF DEFICIENCIES       TAG       SUMMARY STATEMENT OF DEFICIENCIES       PREFIX       TAG       PREFIX       PREFIX <td cols<="" td=""><td>STATEMENT</td><td>OF DEFICIENCIES</td><td>(X1) PROVIDER/SUPPLIER/CLIA</td><td></td><td></td><td>(X3) DAT</td><td>E SURVEY</td></td>	<td>STATEMENT</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td></td> <td></td> <td>(X3) DAT</td> <td>E SURVEY</td>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DAT	E SURVEY
300 NORTH DOW STREET CANNON FALLS       MMUD PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DORHECTIVA AUST BE PRECEDED SY FULL PREFIX     UNITED REACH DORHECTIVA CONSCREPTION (EACH DORHECTIVA CONSCREPTION OF CORRECTION (EACH DORHECTIVA CONSCREPTION) (CONSCREPTION OF LECTION (CONSCREPTION OF LECTION) (CONSCREPTION OF LECTION (CONSCREPTION OF LECTION (CONSCREPTION OF LECTION) (CONSCREPTION OF LECTION (CONSCREPTION OF LECTION OF LECTION (			245304	B. WING		12/	01/2016	
THE GARDENS AT CANNON FALLS       CANNON FALLS, IMI 55009         (X4) 0 PHEFIX TAC       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY NUST BE PRECEDED BY FULL RECULATORY OR LISC IDENTIFYING NFORMATION)       ID PHEFIX TAC       PROVIDERS TURANOF CONRECTIVE ACTION STOLD BE CANDERS REFERENCED TO THE APPROPRIATE DEFICIENCY       CMIMI FIXE (MI FIXE DEFICIENCY)         F 242       Continued From page 10 confirmed the resident receives a weekly bath on Saturdays, but could not verify a bath had been given.       F 242       F 243       F 253       483, 1001(2)       F 243       1/10/17         F 253       483, 1001(2)       HOUSEKEEPING & MAINTENANCE SSEE       F 253       F 253       F 253       1/10/17         INTER EQUIPENT is not met as evidenced by: This REQUIPENT is not met as evidenced by: F 253       Garpet odor in 200 wing: Entire length of the hall was cleaned and disinfected.         Housekeeping and maintenance services necessary to maintain a clean, comfortable interior; This REQUIPENT is not met as evidenced by: F 253       Garpet odor in 200 wing: Entire length of the hall was cleaned and disinfected.         Housekeeping and Maintenance will monitor on a daly basis and clean areas that are solied of have does of urine. Nursing will monitor the residents who may have solied of the area of the hall was toom promoting 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. 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	NAME OF I	PROVIDER OR SUPPLIER						
PHETRY TAG       (EACH CORFECTIVENTS ACTION SHOULD BE CROSS-REFERENCE OT INTERATION)       PMETRY TAG       (EACH CORFECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE       COMMETRY DEFICIENCY         F 242       Continued From page 10 confirmed the resident receives a weekly bath on saturdays, but could not verify a bath had been given.       F 242       F 243       F 243       F 253       HAINTENANCE       F 253       Interview, and the resident receives a weekly, and comfortable interior; This REQUIREMENT is not met as evidenced by:       F 253       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.       F 253       Garpet odor in 200 wing: Entire length of the hall was cleaned and disinfected. Housekeeping and maintenance services accessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by:       F 253       Garpet 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 solied or inaction reterions and are mobile in the hallways and change residents on the 200 wing who are known for having incontinence problems and are mobile in the hallways and change residents who may have solied oldoring. 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.         R13 wheelchair were cleaned, Apolicy and procedure for cleaning wheelchair with end as wheelchair is in need of cleaning. Nursing will label the wheelchair with the residents, name and	THE GAR	RDENS AT CANNON F	ALLS					
<ul> <li>confirmed the resident receives a weekly bath on Saturdays, but could not verify a bath had been given.</li> <li>A policy regarding bathing was requested, none was provided.</li> <li>F 253 483.10(i)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</li> <li>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: 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.</li> <li>Findings include:</li> <li>Observations noted during then huilat tour of 11/28/16, and verified on 12/1/15, at 12:30 p.m. with the environmental director HED) were as follows:</li> <li>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.</li> <li>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].'</li> <li>The strong pungent odor of urine in the hall by the</li> </ul>	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION	
F 253       483.10(i)(2) HOUSEKEEPING & MAINTENANCE       F 253       1/10/17         SS=E       SERVICES       1/10/17         (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;       This REQUIREMENT is not met as evidenced by:       Dased 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.       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 solied 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 thit dots issue will be checked more than daily to ensure odors are maintained at an acceptable level.         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.       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	F 242	confirmed the resid Saturdays, but coul given. A policy regarding b	ent receives a weekly bath on d not verify a bath had been	F 2	42			
		<ul> <li>483.10(i)(2) HOUSI SERVICES</li> <li>(i)(2) Housekeeping necessary to maint comfortable interior This REQUIREMEN by: Based on observat review, the facility fi sanitary environme repair, for residents the potential to affe hundred wing.</li> <li>Findings include:</li> <li>Observations noted 11/28/16, and verifi- with the environment follows:</li> <li>During the initial too strong pungent odd located at the nurse On 11/30/16 at 2:48 surveyor "the carpe unbearable, especi- about it [in regards</li> </ul>	g and maintenance services ain a sanitary, orderly, and "." NT is not met as evidenced tion, interview, and document ailed to maintain a clean, nt, and resident rooms in good s, staff and visitors. This had ct 12 residents on the two during the initial tour on ed on 12/1/16, at 12:50 p.m. ntal director (ED) were as ur on 11/28/16 at 2:48 p.m., a or was present in the hallway es station on the 200 wing. B p.m. R42 complained to the t smells of pee, and becomes ally in the summer, they know to telling staff of the smell]."	F 2	Carpet odor in 200 wing: Entire the hall was cleaned and disinfer Housekeeping and Maintenance monitor on a daily basis and clea that are soiled or have odors of u Nursing will monitor the resident 200 wing who are known for hav incontinence problems and are r the hallways and change resider may have soiled clothing. Rooms cleaned daily and those rooms w issues will be checked more that ensure odors are maintained at a acceptable level. R13 wheelchair and R35 wheelc cleaned. A policy and procedure cleaning wheelchairs will be devi and implemented. The policy will the nursing staff to notify the housekeeping staff when a whee in need of cleaning. Nursing will wheelchair with the resident's na take it to the housekeeping depa	cted. will an areas urine. s on the ing nobile in its who s are vith odors n daily to an hair were for eloped I require elchair is label the me and urtment	1/10/17	
		01 01	,			_		

Facility ID: 00758

If continuation sheet Page 11 of 50

		& MEDICAID SERVICES				MB NO.	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		245304	B. WING _			12/0	1/2016
NAME OF F	PROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
THE GAP	RDENS AT CANNON F	FALLS			0 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 253	Continued From pa	ige 11	F 25	53			
	nurses station, and 200 wing, was note 11/28/16 at 2:48 p.r 11/30/16 at 2:48 p.r On 11/30/16 10:47 that the carpet was length of the 200 ha the door strips to th debris. Hallway car large white stain. Fo located directly outs R13's wheelchair w substance that app in the foot pedals, b the chair upholstery R35's wheelchair w debris, the foot plat dried on food and d R81 was interviewe and stated, "I feel th bedroom floor was puddles of a browr revealed surface da wax surface was ur faucet was leaking orange across the b brownish red all alo extending 6-8 inche R81 stated, "It is ea a new seal, I don't I The bathroom also	also outside of rooms on the d during the survey on m., 11/30/16 at 10:47 a.m., m., and 12/1/16 at 10:15 a.m. a.m. an observation revealed soiled heavily with debris the allway with multiple stains, also be rooms had grime, dirt and pet located outside R23 had a ood debris was observed to be side of R4's room. ras observed to be soiled, a eared to be nuts was built up prown debris was visible and y felt sticky to the touch. ras observed to be soiled with e of the chair was soiled with			to the nursing department. Nursing monitor this daily. R81 sink and stool were cleaned at gaskets have been installed. Floor cleaned. All bathrooms are cleaned daily basis and housekeeping will n maintenance of repairs which need conducted to ensure that broken its are repaired and missing items are replaced. Monitored by housekeepin maintenance daily. R34 privacy curtain was replaced, were patched, sanded and painted Nursing, housekeeping and mainter staff will check rooms daily and on random basis for torn or soiled curt and privacy curtains. When a room vacant, housekeeping does a deep cleaning and replaces the privacy curtains. R4 walls were patched, sanded and painted and ceiling tile was replaced Maintenance and housekeeping wi monitor rooms during cleaning on a basis and note areas that need rep inform maintenance by writing need repairs in the maintenance log on en uursing station. R35 ceiling tile was replaced. Housekeeping, maintenance and n will monitor for ceiling tile repairs at in the maintenance log on each nur unit to notify maintenance of needer repairs. R15 blinds were replaced. Mainten and housekeeping will monitor roor when they are being cleaned on a	nd new was d on a lotify to be ems ing and walls nance a ains is d d. II a daily air and ded each ursing nd note rsing d ance ns	
	On 11/30/16 at 2:21	I p.m., the housekeeper			basis for items that need to be repa replaced and will note items on the	aired or	

Facility ID: 00758

If continuation sheet Page 12 of 50

CENTER	IS FOR MEDICARE	& MEDICAID SERVICES	1		0	FORM / MB NO.	0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY PLETED	
		245304	B. WING _			12/0	)1/2016	
NAME OF F	ROVIDER OR SUPPLIER	• •		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
THE GAP	DENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 253	Continued From pa	age 12	F 25	53				
	mopped the room t recently had a deep there is a strong ur On 11/30/16 at 2:30 soiled and stained substance 4 feet of heavily scraped wit damage behind the On 11/29/16 at 11:7 R4, the ceiling tile i and bowing away fir register is located. have patches of pla There is a 2 inch pi On 11/28/16 at 6:13 interview with R35, observed in the bat During a interview p p.m. 5 inch strips o missing from the w On 11/28/16 at 4:44 R 72, the bathroom wall is damaged, w states that he notifi On 11/28/16 at 4:44 been found to be sip	<ul> <li>D p.m. R34 privacy curtain is with a reddish brown color if of the floor. The walls were h missing paint and surface e chair and the bed.</li> <li>16 a.m. during a interview with s observed to be discolored, rom the strip where the heat The walls in the bathroom aster, they are not painted. Here of ceiling tile missing.</li> <li>B p.m. during the initial cracked ceiling tile is throom.</li> <li>with R15 on 11/28/16 at 6:49 f blinds are observed to be</li> </ul>			maintenance logs on each nurses a to notify maintenance of needed re replacements. Wall paper in the 200 wing hallway patched and repaired where the wa board was exposed. All building ha and rooms where wallpaper is on the surface will be monitored by housekeeping and and maintenance daily basis as they work throughout building. Existing damage to walls of patched and painted. Monitored by Maintenance, Housek and Administration	pairs or was all llways ne ce on a t the will be		
	On 12/1/16 at 12:3 hallway between ro	0 p.m. Wall paper in the om 217-219, and						

If continuation sheet Page 13 of 50

DEPART		FORM	APPROVED					
		& MEDICAID SERVICES			0938-0391			
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
		045004	B. WING					
	PROVIDER OR SUPPLIER	245304		STREET ADDRESS, CITY, STATE, ZIP CODE	12/	01/2016		
NAME OF 1	ROVIDER OR SUPPLIER			300 NORTH DOW STREET				
THE GAR	THE GARDENS AT CANNON FALLS			CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
F 253	multiple areas revea On 12/1/16 at 12:30 was a 5 inch x 16 for wall, ceiling tiles we missing. There is a the wall is damaged through out revealin below. There was a but had not been sr During the tour on the verified the houseker room and bathroom carpet should be re discussed in a mee The ED stated the h staff were responsil were needed. When presented a clip boo communication, wh issues in need of re the communication	I multiple torn/scraped off in aling the wallboard below. D p.m. in the dining room there bot long black mark along the there noted to have pieces 18 inch by 4 foot area where d. The wall paper was missing ing a damaged wall board thick layer of plaster applied noothed nor painted. 12/1/16 at 1:30 p.m., the ED eeping staff cleaned each in daily. He confirmed that the placed and that it was ting, but not budget approved. housekeepers and nursing ble to report when repairs in in the 200 wing the ED ard that was used for en there were environmental pair. There were no notes on	F 25:					
F 278 SS=D	paper titled mainter unaware of a policy 483.20(g)-(j) ASSE	nance repair list. He was for maintenance.	F 278	3		1/10/17		
	must accurately ref	essments. The assessment lect the resident's status. must conduct or coordinate <i>v</i> ith the appropriate						

Facility ID: 00758

If continuation sheet Page 14 of 50

		AND HUMAN SERVICES			RINTED: 02/02/2017 FORM APPROVED MB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245304	B. WING		12/01/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	IDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 278	Continued From pa participation of hea	-	F 278	3		
	<ul><li>(i) Certification</li><li>(1) A registered nur</li><li>the assessment is of</li></ul>	se must sign and certify that completed.				
		who completes a portion of the sign and certify the accuracy of ssessment.				
	(j) Penalty for Falsif (1) Under Medicare who willfully and kn	and Medicaid, an individual	C			
	resident assessme	ial and false statement in a nt is subject to a civil money than \$1,000 for each				
	and false statemen	individual to certify a material t in a resident assessment is oney penalty or not more than sessment.				
	material and false s This REQUIREMEN	ement does not constitute a statement. NT is not met as evidenced				
	review, the facility	tion, interview and document ailed to accurately code the (MDS) assessment for 1 of 1 ewed for oral/ nutritional		A modification of the 14 day MD for was submitted the day it was noted survey team. The MDS Coordinato review and check all the section of MDS For accuracy of other departr entries and confirm the information	l by the r will the nents	
	Findings include: R45's Minimum Da assessment dated	ta Set (MDS) 5 day 10/14/16, identified the		the care plan with each MDS (at le quarterly). Completion date 1-10-2017 Monitored by the MDS Coordinator		

Facility ID: 00758

STATEMEN	F OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
	PROVIDER OR SUPPLIER	245304	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	12	/01/2016	
	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 278 F 279 SS=D	resident as having R45's MDS 14 day identified the reside and mechanically a During an observat R45 was observed independently hot of breakfast tray with located on the tray. When interviewed of dietary manager (D feeding tube and co coding on the MDS 483.20(d);483.21(b COMPREHENSIVE 483.20 (d) Use. A facility m assessments comp months in the resid results of the asses and revise the resic plan. 483.21 (b) Comprehensive each resident, cons set forth at §483.10 includes measurab to meet a resident's	a mechanically altered diet. assessment dated 10/19/16, ent as having tube feedings litered diet. ion on 11/29/16, at 8:59 a.m. to be feeding herself patmeal cereal and had a other regular foods and liquids on 11/30/16, at 2:00 p.m. the M) verified R45 never had a onfirmed it was an inaccurate dated 10/19/16. )(1) DEVELOP E CARE PLANS nust maintain all resident pleted within the previous 15 ent's active record and use the ssments to develop, review dent's comprehensive care Care Plans t develop and implement a son-centered care plan for sistent with the resident rights 0(c)(2) and §483.10(c)(3), that le objectives and timeframes is medical, nursing, and mental eeds that are identified in the	F 27			1/10/17	

If continuation sheet Page 16 of 50

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/02/2017 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED			
		245304	B. WING		12/	01/2016			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
THE GAR	RDENS AT CANNON F	ALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE			
	REGULATORY OR L Continued From pa care plan must des (i) The services tha or maintain the resi physical, mental, ar required under §48 (ii) Any services tha under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative servic provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation v resident's represen (A) The resident's g desired outcomes. (B) The resident's p future discharge. Fa whether the resider community was ass	ge 16 cribe the following - t are to be furnished to attain dent's highest practicable ind psychosocial well-being as 3.24, §483.25 or §483.40; and it would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document it's desire to return to the sessed and any referrals to ies and/or other appropriate		DEFICIENCY)	RIATE	DATE			
	plan, as appropriate requirements set fo section.	s in the comprehensive care e, in accordance with the rth in paragraph (c) of this NT is not met as evidenced							

If continuation sheet Page 17 of 50

		E & MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245304	B. WING		12/0	01/2016	
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
THE GAP	RDENS AT CANNON	FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 279	Continued From pa	age 17 v and document review, the	F 27	9 Care plan for R72 has beer	reviewed and		
	care for 1 of 2 resid of substance abuse drugs. Findings include: R72's progress not R72 had a canister note indicated the canister when he for police, due to his p substance in the fa further indicated the contained the illega	velop a comprehensive plan of dents (R72) who had a history e and possession of illegal tes dated 10/3/16, indicated r of marijuana in his room. The resident attempted to hide the ound out the staff called the ossession of an illegal acility. The progress note e police confirmed the canister al substance of marijuana. uress notes dated 11/8/16,	C	updated to include focus, go interventions with history of a current use of illegal substar order added to PCC for nurs for sign of substance abuse possession which include no authorities if illegal substance identified, which will protect residents. Newly discovered be added to the individualized by the appropriate department discovered. Nurse manager resident's chart weekly or m for notes regarding illicit sub and/or presence. Completion date 2-1-2017	and potential nces. Nursing the to observe and otifying local es are other d issues will ed plan of care nt as they are to review ore frequently		
	indicated R72 was pipe in his room, w facility investigating included the police confirmed for marij Review of R72's of admission diagnos abuse with intoxica abuse, major depro	observed to have a marijuana hile the police were at the g a complaint. The note further tested the pipe and it was		Monitored by Nurse Manage MDS Nurse	rs, DON and		
	(MDS) dated 8/18/ diagnosis that inclu abuse along with a						
	include the resider	urrent plan of care did not its history of drug abuse nor oring for possession of illegal					

If continuation sheet Page 18 of 50

		& MEDICAID SERVICES				. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY	
		245304	B. WING		12/01/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
THE GAI	RDENS AT CANNON F	ALLS					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 279	Continued From pa	ge 18	F 27	79			
	12/2/16, at 1:00 p.n did not include mon possession of illega						
F 282 SS=D	483.21(b)(3)(ii) SEF PERSONS/PER CA	RVICES BY QUALIFIED ARE PLAN	F 28	32		1/10/17	
		ive Care Plans led or arranged by the facility, omprehensive care plan,					
	care. This REQUIREMEN	qualified persons in ch resident's written plan of NT is not met as evidenced	C				
	review, the facility fa (R42) reviewed for provided assistance	tion, interview and document ailed to ensure 1 of 3 residents activities of daily living was with oral hygiene and ance with the care plan.		R42's care plan updated t resident is able to dictate p and will be encouraged to own cares and when unab that staff assist her.	ersonal cares perform her		
	Findings include:			Resident R42 has been ind new resident dignity groom	ing program.		
	diagnosis of paraple			Residents have had their c reviewed and grooming an corrections were made as	d ADL necessary.		
	9/23/16 indicated a Status (BIMS) score	num Data Set (MDS), dated Brief Interview for Mental e of 15 (cognitively intact). The R42 required extensive		Nursing will be inserviced l proper care planning to ad the new resident dignity groprogram.	dress ADLs and		
	assistance of two s	taff for grooming activities.		A new care planning progra put into place that includes	a strong focus		
	of daily living (ADLs R42 was totally dep	sessment (CAA) for activities b), printed 12/1/16 indicated bendent upon staff in all ADLs briented. Proceed to care plan		on grooming and ADLs. A dignity grooming checklist developed. This checklist a daily basis to evaluate ar	has been vill be used on		

Facility ID: 00758

If continuation sheet Page 19 of 50

		& MEDICAID SERVICES	1		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245304	B. WING		12/0	1/2016
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STAT	E, ZIP CODE	
THE GAI	RDENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 550	09	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE	(X5) COMPLETIOI DATE
F 282	Continued From pa	age 19	F 2	82		
	R42's care plan, da	level of functioning. ated 12/1/16 indicated R42		residents are receivin and ADL care accordi Unit managers will au	ng to care plan. dit 10% of residents	
	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.			weekly x 4 weeks and thereafter to ensure the dignity grooming check properly used. All com will be delivered to the her or her designee. The DON or her designee	hat the new resident sklist is being apleted checklists a DON for review by	
	stated she was tryin	n 11/28/16, at 5:42 p.m. R42 ng to use dry shampoo on her vays even get her hair brushed	C	the OA committee mo	nthly.	
	at 10:13 a.m. nursi washed their hands uncovered R42's u cleanse R42's skin apply powder bene uncovered R42's lo underneath the skin perineal area, rolled	of morning cares on 12/1/16, ng assistant (NA)-A and NA-B s and applied gloves, pper half and proceeded to folds and underarms and ath the folds. NA-A and NA-B ower half of her body, cleaning n folds of the abdomen and d R42 on her side and eal area. After removing their				
	gloves and disposin plastic bag, license proceeded to provin pressure ulcer, rem dressing materials, antibacterial solution	an area. After removing their ng of the soiled linens into a d practical nurse (LPN)-A de wound care to R42's noving the soiled wound irrigating the wound with an on, cleansing her hands and the wound with new dressing				

If continuation sheet Page 20 of 50

		AND HUMAN SERVICES			FORM	: 02/02/2017 APPROVED . 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		245304	B. WING		12	/01/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GA	RDENS AT CANNON	FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 282 F 285 SS=D	room. NA-A and N/ gloves and wash the without offering R4. offering to brush he During interview on stated she would he teeth after morning normal, wouldn't it? During interview on registered nurse (F expected staff to of materials to brush ficture care supplies with the A policy related to a grooming was requided to grooming was requided to a grooming was requided to a	A-B proceeded to remove their neir hands, and exited the room 2 her oral care materials nor er hair or giving her the brush. 12/1/16, at 11:13 a.m. R42 ave liked to brush her hair and cares, "That would be kind of " 12/1/16, at 11:24 a.m. N)-B stated she would have fer R42 her grooming her hair as well as her oral morning cares. activities of daily living and lested, none was provided. PASRR REQUIREMENTS dinate assessments with the eening and resident review n under Medicaid in subpart C haximum extent practicable to osting and effort. Coordination e recommendations from the etermination and the PASARR to a resident's assessment,	F 2			1/10/17	

If continuation sheet Page 21 of 50

DEPARTMENT OF HEALTH AI CENTERS FOR MEDICARE &		FORM APPROVED OMB NO. 0938-0391					
	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	245304	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				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
<ul> <li>F 285 Continued From page significant change in section of the individual red services pand</li> <li>(k) Preadmission Screemental disorder and in disability.</li> <li>(1) A nursing facility m January 1, 1989, any</li> <li>(i) Mental disorder as (i) of this section, unleathority has determinindependent physical performed by a person State mental health at (A) That, because of the level of services pand</li> <li>(B) If the individual red services, whether the specialized services; of (ii) Intellectual disability of this section intellectual disability of the level of services pand</li> <li>(B) If the individual red services pand</li> </ul>	e 21 status assessment. reening for individuals with a individuals with intellectual nust not admit, on or after new residents with: defined in paragraph (k)(3) ess the State mental health ned, based on an and mental evaluation on or entity other than the authority, prior to admission, the physical and mental dual, the individual requires provided by a nursing facility; equires such level of e individual requires or ity, as defined in paragraph on, unless the State or developmental disability ined prior to admission- the physical and mental dual, the individual requires provided by a nursing facility;	F 28	DEFICIENCY)				

If continuation sheet Page 22 of 50

DEPART	FO	RM APPROVED					
		& MEDICAID SERVICES				NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING			12/01/2016	
NAME OF F	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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE	
F 285	Continued From pa	ge 22	F 2	285			
	(2) Exceptions. For	purposes of this section-					
	paragraph(k)(1) of t for determinations i to a nursing facility being admitted to th transferred for care (ii) The State may c preadmission scree paragraph (k)(1) of to a nursing facility (A) Who is admitted hospital after receiv hospital, (B) Who requires no condition for which the hospital, and (C) Whose attending before admission to	hoose not to apply the ning program under this section to the admission					
		ourposes of this section-					
		onsidered to have a mental dual has a serious mental 483.102(b)(1).					
	intellectual disability intellectual disability	considered to have an / if the individual has an / as defined in §483.102(b)(3) a related condition as					

		AND HUMAN SERVICES	FORM APPROVED				
		& MEDICAID SERVICES				0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245304	B. WING _		12/0	01/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GAI	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION		
F 285	described in 435.10 (k)(4) A nursing fac mental health authority, a significant change i condition of a reside intellectual disability This REQUIREMEN by: Based on interview facility failed to ensu R81) reviewed for p had history of serior Level II preadmission review (PASRR) on Findings include: R56's face sheet, d primary diagnoses of depressive disorder An initial pre-admiss Senior Linkage Line primary diagnosis of of mental illness. A social services pri indicated staff were related to the Level follow-up phone cal was charted or prov During interview on stated he routinely shealth issues and h	2010 of this chapter. 2010 of this chapter.	F 28	5 Social Worker has notified Goodh County that Level II screenings are required for R56 and R81, and is a completion and delivery of screenin Call placed weekly to check on pro while awaiting screenings. Level I pre-admission screening will be rev or completed as needed by Admiss prior to admission. Admissions wil to Social Services if level II screeni indicated. Social Worker will notify appropriate county to complete lev screening. Tracking log to be kept Social Services office, monitoring t completed by Social Worker with e MDS Assessment (at least quarter Completion date 1-10-2017 Monitored by MDS and Social Serv	waiting ngs. gress viewed sions I report ng is the el II in o be ach y).		

If continuation sheet Page 24 of 50

		AND HUMAN SERVICES				FORM	02/02/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245304	B. WING _			12/(	01/2016
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP (	CODE		
THE GA	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD I	BE	(X5) COMPLETION DATE
F 285	During interview on social worker (SW) for a Level II PASR another facility in 10 called the county pr PASRR, but was ur have one on file for On 11/30/16, at 9:1 for R56 was faxed to County, indicating F mental illness and of services. During interview on previous county case did require mental f been set up in his p and would not requi- services. CW-A was PASRR assessmen R81's face sheet, d primary diagnoses is schizophrenia. The (EMR) included sch listed under the diag An initial pre-admis Senior Linkage Line primary diagnosis of was checked for the (Omnibus Budget F federal program that individuals with seri Developmental Disa are requesting admit to determine the mo-	<ul> <li>11/29/16, at 3:44 p.m. the</li> <li>-A confirmed R56 met criteria</li> <li>R and had been admitted from D/16. SW-A indicated she had reviously to check on the nsure of the status and did not R56.</li> <li>0 a.m. a Level II PASRR form to SW-A from Goodhue</li> <li>R56 had documented history of did not need specialized</li> <li>11/30/16, at 9:14 a.m. R56's se worker (CW)-A stated R56 had present county of residence ire any other specialized s not sure of the status o</li></ul>	F 2				

If continuation sheet Page 25 of 50

		AND HUMAN SERVICES			FORM	: 02/02/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245304	B. WING		12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GAF	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 285 F 285 F 309 SS=G	Continued From pa Level II Mental Hea of the need for spec On 11/29/16, at 5:0 regarding the lack of Screening and Res screening. The Sen was reviewed with t the need for the Lev and confirmed there On 11/29/16, at 5:3 director of nursing a were together in the interviewed , they s R81 lacked a Level On 12/1/16, at 10:5 PASRR form, from faxed to the SW-A. documented history need specialized set A policy related to F requested, none wa 483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of lif Quality of life is a fu applies to all care a residents. Each res facility must provide services to attain or practicable physical	age 25 alth Evaluation and final review cialized services is required." 7 p.m., SW-A was interviewed of a Level II Pre-Admission ident Review (PASRR) hior Linkage Line document the SW-A. The SW-A stated vel II screening was missed e was not one on file. 0 p.m. the administrator, and admission coordinator e administrator's office. When tated they were not aware of II PASRR. 7 a.m. an unsigned Level II Goodhue County, for R81 was The form indicated R81 had y of mental illness and did not ervices. PASRR assessments was as provided. ) PROVIDE CARE/SERVICES ELL BEING	F 2	285		12/27/16
		sessment and plan of care.				

Facility ID: 00758

If continuation sheet Page 26 of 50

	-	AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED	
		245304	B. WING		12/(	01/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GAP	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	483.25 (k) Pain Manageme The facility must en provided to resident consistent with prof the comprehensive and the residents' g (l) Dialysis. The fac residents who requi services, consistent of practice, the com care plan, and the r preferences. This REQUIREMEN by: Based on interview facility failed to ensu control chronic mod available timely for for pain control. R42 when the facility wa medication supply f pharmacy provided time R42 experienc Findings include: R42's face sheet da diagnoses of parap pain syndrome. R42's annual Minim 9/23/16, indicated a Status (BIMS) score intact. The MDS als needed pain medica	ent. sure that pain management is is who require such services, essional standards of practice, person-centered care plan, oals and preferences. sility must ensure that re dialysis receive such the dialysis receive such the with professional standards prehensive person-centered esidents' goals and NT is not met as evidenced and document review, the ure narcotic pain medication to lerate to severe pain was 1 of 1 resident (R42) reviewed 2 experienced actual harm s out of the narcotic or three days before the the medication, during which	F3	09 Resident #42 was seen by a physic pain and a new program was put im place to ensure that pain medication always available. Under the direction of the DON, nur conducted a review of all residents pain medication to ensure appropria availability and delivery of pain medications is taking place. Correct were made as required. Nurses will be in-serviced on 1-4-17 ordering medications including narco and e-kit use to ensure that medica including narcotics are properly ord so they are always available for res with orders for them. This training w include steps to be taken for various medication scenarios, including res refusing pain medications on hand, increased narcotic usage and preve a rapid depletion of any back-up na The evening nurse manager will au narcotic supplies routinely on Mond	to ns are rsing on ate tions 7 on cotics tions, ered idents vill s pain ident enting rcotic. dit		

Facility ID: 00758

If continuation sheet Page 27 of 50

		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED	
		245304	B. WING		12	2/01/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
THE GA	RDENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE	
F 309	Continued From pa	age 27	F 30	9			
	R42's Care Area A indicated R42 had that limited her day indicated R42 was request pain medic R42's care plan las R42 was at risk for of having discomfo included administe for pain. R42's physician's c orders for oxycodo analgesic) 5 milligr every four hours as related to chronic p orders also identifie patch 25 micrograf well as gabapentin nerve pain) 400 mg chronic pain syndro R42's pain intervier indicated R42 expe which was modera assessment indica four out of ten (10 and indicated R42 R42's medication a dated 11/16 indicat oxycodone 5 mg ta the month of Nove ranging from a ten The November 20	ssessment (CAA) for pain almost constant moderate pain <i>y</i> -to-day activity. The CAA alert, oriented and able to cations. at revised 7/10/16, indicated impaired comfort with a goal ort less than daily. Interventions ring medications as ordered orders dated 12/1/16, identified ne (a short acting narcotic am (mg) tablets by mouth s needed (PRN) for pain bain syndrome. The physician's ed Fentanyl (a narcotic) pain ms every 72 hours topically, as (a medication used to treat g by mouth three times daily for ome. w assessment dated 9/23/16, erienced pain almost constantly te in intensity. The pain ted R42 rated the pain as a being the most severe pain), indicated a 4 was tolerable. administration record (MAR) ted R42 had received ablets a total of 14 times during mber 2016 for pain levels to a five on a ten-point scale. 16 MAR indicated R42 had not boone from 11/14/16 to		and Thursdays to ensure adequate supply of narc and that all re-orders ha on file at the pharmacy. and the DON will be adv narcotic supply is low. The Director of Nursing will audit back-up narcot sufficiency weekly x 4 ar thereafter. The DON or of report monthly to the QA	otics is on hand ve current scripts Unit managers ised when the or her designee ic supplies for nd then monthly designee will		

If continuation sheet Page 28 of 50

		AND HUMAN SERVICES				RINTED: 02/02/2017 FORM APPROVED //B NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245304	B. WINC	à		12/01/2016
NAME OF I	PROVIDER OR SUPPLIER				CITY, STATE, ZIP CODE	
THE GAR	RDENS AT CANNON F	FALLS		300 NORTH DOW S CANNON FALLS,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	TIX (EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 309	and 17, 2016. R42 acetaminophen dos 11/15/16, was ident R42 had received a acetaminophen for 11/16/16, at 4:30 a. level 5 and received acetaminophen. At rated her discomfor note dated 11/17/16 had been calling ou nerves." The note had orders for oxyc medication had run from the pharmacy. the resident continu given PRN Tylenol Even though R42 e required as needed follow up notes on t recored (MAR) indie each dose of aceta R42's narcotic log s October and Noven oxycodone supply f 11/13/16, and a new in until four days lat dose administered 11/17/16. During interview on stated she had exp days when she did stated she thought due to the doctor ne	00 mg on November 15, 16 's pain level listed for an se given at 9:56 a.m. on iffied as a 6. At 10:01 p.m.,	d n ed	309		
FORM CMS-25	567(02-99) Previous Versions		411	Facility ID: 00758	If continuation	on sheet Page 29 of 50

		AND HUMAN SERVICES				RINTED: 0 FORM AF MB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245304	B. WING	à		12/01	/2016
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, S	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON F	FALLS		300 NORTH DOW STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPF EFICIENCY)	BE C	(X5) COMPLETION DATE
F 309	2016. R42 stated n oxycodone from the supply. When aske had gotten, R42 sta a nine!" The nine w scale and 9 bing ex oxycodone helped if experienced in her During a follow-up if p.m. R42 clarified h (worse than excruc when she had not r (between 11/13 and The director of nurs 11/30/16 at 4:32 p.r R42 had run out of 11/13/16, and confi expected staff to ca to provide coverage supply. The DON s the facility's policy r supplies of medicat stated registered nu person to ask abou During interview wit (LPN)-B on 12/1/16 the procedure to get the pharmacy inclus getting authorizatio the emergency kit. staff had difficulty p narcotics from the p needed a new scrip	vas taken care of in Novemb o one had offered her e facility's emergency narcot d how severe her pain level ated "Oh, my [expletive] it wa vas based on a 1 to 10 pain corutiating. R42 said the manage the nerve pain she hands. interview on 11/30/16, at 3:5 her pain had been an 11 iating) during the time period received the oxycodone d 11/17/16). sing (DON) was interviewed m., she stated she was awar her oxycodone around rmed she would have all the doctor on call to be ab e from their emergency kit tated she was unsure about related to procuring emerger tion from the pharmacy. She urse (RN)-B would be the be at 8:05 a.m., LPN-B stated at 8:05 a.m., LPN-B stated at emergency narcotics from ded calling the pharmacy an n to take a medication from LPN-B indicated sometimes procuring re-order supply of pharmacy when the pharmacy	er iic as 1 1 d 1 d d von re ble est ble est	309			
FORM CMS-25	567(02-99) Previous Versions			Facility ID: 00758	If continuation	on sheet Pa	ge 30 of 50

	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM A	02/02/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
	245304	B. WING		12/01/2016	
NAME OF PROVIDER OR SUPPLIEF	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GARDENS AT CANNON	FALLS		00 NORTH DOW STREET CANNON FALLS, MN 55009		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
<ul> <li>on 11/13/16. LPN medication label to days before it ran faxed the pharmatic came in due to the script for the media not realize for a wa a new prescription R42's physician for during the time R4 oxycodone, LPN-4 and the acetaminate expressed was effered by the additional several days between RN-B said the methe pharmacy but sometimes had transfacility should have physician to get at oxycodone when I available in their effert and the acetaminate expression of the prescriptions of</li></ul>	d R42 running out of oxycodone l-A stated she had pulled the o re-order the medication a few out. LPN-A also stated she had cy for more supply which never e pharmacy requiring a renewed ication. LPN-A stated staff did hile that the pharmacy required n. She said they had then faxed or the new prescription and 42 was waiting for her A recalled offering gabapentin ophen which she said R42 had fective. In 12/1/16 at 10:09 a.m., RN-B d run out of oxycodone for reen 11/13/16 and 11/17/16. dication renewal was faxed to never came, and that staff ouble getting medication when	C			

If continuation sheet Page 31 of 50

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMPLETED	
		245304	B. WING _		12/	01/2016
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HE GAF	IDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 309	Continued From pa	ge 31	F 30	99		
	•	o facility more promptly than				
F 312 SS=D		CARE PROVIDED FOR	F 31	2		1/10/17
	activities of daily liv services to maintain personal and oral h This REQUIREMEI by: Based on observat review, the facility f and grooming need provided for 1 of 3 were dependent up activities of daily liv Findings include: R42's face sheet, d diagnosis of parapl Data Set (MDS), da Interview for Menta (cognitively intact). required extensive grooming activities. R42's care area as of daily living (ADLs R42 was totally dep	NT is not met as evidenced tion, interview and document ailed to ensure oral hygiene Is (hair combed) were residents (R42) reviewed who toon staff assistance with ing (ADL). lated 12/1/16 identified a egia. R42's annual Minimum ated 9/23/16 indicated a Brief I Status (BIMS) score of 15 The MDS also identified R42 assistance of two staff for sessment (CAA) for activities s) printed 12/1/16, indicated bendent upon staff for all ADL's ted. Proceed to care plan to	C	Resident #42 has a new ADL pr place which includes oral care a grooming; this is being provided A new policy on oral care and AD grooming has been developed. If have been reviewed to ensure th are receiving appropriate ADL ca grooming, and oral care. Nursing staff – nurses and NARs re-trained on the elements of pro care for residents, ADL care, and grooming. Return demonstration required to ensure adequate cor with training. A new resident dignity program h developed which involves review resident care daily to ensure tha grooming has been done proper combed, fingernails cleaned, pro bathing, and oral care. A form cr a checklist will be used to evalua residents daily. Unit managers or their designee	nd daily. DL Residents hat they are, s – will be oper oral d s will be npliance has been ring t ly, hair oper eated as tte	

Facility ID: 00758

If continuation sheet Page 32 of 50

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY		
FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	IPLETED		
	245304	B. WING _		12/	01/2016		
ROVIDER OR SUPPLIER				ZIP CODE			
DENS AT CANNON	FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE		
Continued From page 32		F 31	2				
hygiene.							
During interview on	n 11/28/16, at 5:42 p.m. R42						
stated she was trying to use dry shampoo on her			are being managed prop	oerly. After			
	vays even get her hair brushed						
•			The Director of Nursing	will report monthly			
			to the QA Committee or	this program.			
uncovered R42's lo	ower body, cleaning						
gloves and disposi	ng of the soiled linens into a						
change materials. I	NA-A and NA-B completed						
device beneath R4	2 and cover her up with her						
	ROVIDER OR SUPPLIER DENS AT CANNON I SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa hygiene. During interview or stated she was tryi hair and did not alw on a daily basis. During observation at 10:13 a.m. nursi washed their hands uncovered R42's u cleanse R42's skin powder beneath the uncovered R42's u cleanse R42's skin powder beneath the uncovered R42's lo underneath the skin perineal area, rolled cleansed her pering gloves and disposin plastic bag, license proceeded to provi pressure ulcer, rend dressing materials, antibacterial solution proceeding to pack change materials. I a.m. cares after LP NA-A and NA-B pro- side and placed ar device beneath R4 bed linen. LPN-A tu and exited the roor to remove their glo exited the roor witt materials nor offeri her the brush to co	245304         ROVIDER OR SUPPLIER         DENS AT CANNON FALLS         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 32 hygiene.         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	245304         B. WING         ROVIDER OF SUPPLIER         DENS AT CANNON FALLS         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 32 hygiene.         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.         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 f42's pressure ulcer, removing the soiled wound dressing 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 with new dressing change materials. NA-A and NA-B proceeded to remove their gloves and wash their hands, and exited the room. NA-A and NA-B proceeded to remove their gloves and wash ther hair or giving her the brush to complete it independently.         During interview on 12/1/16, at 11:13 a.m. R42 stated she would have liked to brush her hair and	245304     B. WING       DENS AT CANNON FALLS     STREET ADDRESS, CITY, STATE, J. 300 NORTH DOW STREET CANNON FALLS, MN 55002       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECODED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREVIDER'S PARTOR (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC MALL SC IDENTIFYING INFORMATION)     PREVIDER'S PLAN OR (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC MALL SC IDENTIFYING INFORMATION)       Continued From page 32 hygiene.     F 312       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.     F 312       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 lower body, cleaning underneath the folds. NA-A and NA-B uncovered R42's lower body, cleaning underneath the folds. NA-A and NA-B uncovered R42's lower body, cleaning underneath the folds. NA-A and NA-B proceeded to gractical nurse (LPR)-A proceeded to practical nurse (LPR)-A proceeded to roll R42 on the rais and proceeding to pack the wound with nan antibacterial solution, cleansing hen mands and proceeding to pack the wound with nan antibacterial solution, cleansing hen mands and proceeding to pack the wound with nan antibacterial solution, cleansing hen mands and proceeding to pack the wound with new dressing change materials. NA-A and NA-B proceeded to remove their gloves and wash their hands, 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 off	245304     B. WING		

If continuation sheet Page 33 of 50

		AND HUMAN SERVICES			FORM	02/02/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245304	B. WING	l	12/	01/2016
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COE 300 NORTH DOW STREET CANNON FALLS, MN 55009	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 312 F 318 SS=D	registered nurse (R expected staff to of materials to brush H care supplies with r A policy related to a	12/1/16, at 11:24 a.m. N)-B stated she would have fer R42 her grooming her hair as well as her oral morning cares. Activities of daily living and ested, none was provided. CREASE/PREVENT		312		1/10/17
	receives appropriat increase range of n decrease in range of (3) A resident with I appropriate service to maintain or impro practicable indeper mobility is demonst	imited mobility receives s, equipment, and assistance ove mobility with the maximum idence unless a reduction in				
	Based on observative review the facility fa (ROM) exercises were commended by the of 2 residents (R42) had limited ROM. Findings include: R42's face sheet, d	tion, interview and document ailed to ensure range of motion rere performed as he physical therapist (PT) for ) reviewed for ROM and who lated 12/1/16 identified a egia. R42's annual Minimum		Resident #42 has a new syst to ensure physical therapy wil performed as ordered by the p Other residents receiving physion or functional maintenance hav programs reviewed and a syst to ensure that they are receiving therapy. This system is the sate explained below, designed to deficiency. Nursing and therapy staff hav	I be ohysician. sical therapy ve had their tem installed ing their the as that correct the	

Facility ID: 00758

If continuation sheet Page 34 of 50

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	[IPLE	CONSTRUCTION		0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		COM	PLETED
		245304	B. WING _			12/01/2016	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
THE GAP	RDENS AT CANNON	FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 318		sessment dated 9/23/16,	F 3		trained on a new method to ensu		
	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.			residents receive their therapy as by the physician. A calendar has created and designated solely for therapy. Each unit has a copy, ea manager, the therapy departmen Director of Nursing. Each week, a meeting, the IDT will review the t	been r resident ach unit t, and the at the IDT		
	printed 12/1/16, inc dependent upon st able to be out of be pressure ulcer. The to no voluntary mov extremities, was ex all ADLs and was a	sessment (CAA) for ROM dicated R42 was totally aff for transfers and was only ed one hour daily due to a e CAA identified R42 had little vement in the bilateral lower stensively dependent on staff in alert and oriented. Proceed to ain current level of functioning.	C		calendar to ensure that resident i are listed there. Each shift, physi therapy and nursing check the ca and mark off once therapy is con This is done for each resident to that their therapy is completed. The DON or her designee will do audit of the resident therapy cale ensure compliance. The head of	herapies cal llendar pleted. ensure a weekly ndar to	
	R42's care plan da limited range of mo to paraplegia and r identified R42 had in place but exhibite daily refusals. No p	ted 12/1/16, indicated R42 had otion to the left hand secondary non-use. The care plan multiple restorative programs ed non-compliance and nearly program was listed for lower motion on the care plan.			will also do his/her own weekly a ensure follow-through on the par staff. The DON and head of therapy wi monthly to the QA Committee on program.	udit to of her Il report	
	recommendations, to perform passive bilateral foot, ankle internal/external ro abduction/adductio Program in binder	tation and hip n x 10 [repetitions] each. hanging on closet, initial npleted. To be done 3 x/week					
	11/2016 reflected of	ress notes for 8/2016 - one entry related to range of corded on 11/17/16 at 1:38					

If continuation sheet Page 35 of 50

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	02/02/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245304	B. WING			12/	01/2016
NAME OF PROVIDER OR SU	PPLIER	·		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
THE GARDENS AT CAN	INON I	FALLS			300 NORTH DOW STREET CANNON FALLS, MN 55009		
PREFIX (EACH DEF	ICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
unable to be [R42's] leg.During interv stated she w to her lower of program inst taped to the for staff to ini No initials we R42 stated th exercises wayDuring interv activities dire the restorativ eliminated ar The position knowledge a exercises no maintenance documentedDuring interv activities dire the restorativ eliminated ar The position knowledge a exercises no maintenance documentedDuring interv practical nurs perform ROM not lift them.During interv getting done stated the re- eliminated th been replace	try ind perfor iew on as not extrem ruction front o tial the ere sign lew on ctor ( <i>A</i> re aide nd now had no had no progr in Poin iew on se (LP <i>A</i> to R <sup>4</sup> iew on apist ( orter of progr storativ e prev d to ho	icated the exercises were med due to unable to lift 11/18/16, at 5:43 p.m. R42 receiving her range of motion nities. A functional maintenance a sheet, dated 8/19/16 was f her closet next to a calendar e ROM exercises labeled 9/16. ned off on the calendar and time she had received the /2016. 11/30/16, at 11:31 a.m. the AD) stated that she used to be e, however that position was v she was assigned activities. ot been replaced to her e was unsure who was doing t the restorative/functional am participation was usually	F	318			

If continuation sheet Page 36 of 50

		AND HUMAN SERVICES			FORM	02/02/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245304	B. WING		12/01/2016	
NAME OF I	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GA	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 318	trouble keeping her wheelchair, and sin the functional main very important to pr the lower extremitie and performed an a ROM at this time, li ROM. The PT state five degrees of dors had increased tone but had no new cor When interviewed or registered nurse (R extremity ROM was was "Too heavy," at the program. During interview on director of nursing ( why R42's restorati extremities was not RN-B would be the the lack of implement Restorative program requested for R42 f provided. The facility policy en Exercises, undated the exercises were individual who perfor range of motion exe exercise and how th procedure, problem	r legs on her footrests in the ice R42 was not able to get up, tenance programming was revent further contractures of es. The PT went to R42's room assessment of R42's lower fiting R42's legs to perform ed R42 had lost approximately siflexion in both of her feet and and was "tight" in both legs, ntractures. on 12/1/16, at 11:24 a.m. the RN)-B stated R42's lower is not performed because R42 nd also due to R42 refusing 12/1/16, at 11:23 a.m. the (DON) stated she was not sure ve program for her lower t being implemented and that best person to question about entation. m documentation was from Point of Care, none was ntitled Range of Motion I indicated the date and time performed, name of the ormed the procedure, type of ercise given, whether the ve or active, length of the he resident participated in the ns or complaints made by the ent refusals should be	F 318			

If continuation sheet Page 37 of 50

		AND HUMAN SERVICES		FORM	APPROVED	
		& MEDICAID SERVICES				<u>. 0938-0391</u>
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245304	B. WING _		12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAP	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		LD BE	COMPLETION DATE
F 334 SS=E	483.80(d)(1)(2) INF PNEUMOCOCCAL		F 33	34		1/10/17
	(d) Influenza and pr	neumococcal immunizations				
	(1) Influenza. The fa and procedures to e	acility must develop policies ensure that-				
	each resident or the receives education	ne influenza immunization, e resident's representative regarding the benefits and s of the immunization;				
	immunization Octob annually, unless the	offered an influenza per 1 through March 31 e immunization is medically he resident has already been his time period;	C			
		the resident's representative to refuse immunization; and				
		nedical record includes indicates, at a minimum, the				
		nt or resident's representative ation regarding the benefits ffects of influenza				
	immunization or did	nt either received the influenza I not receive the influenza o medical contraindications or				
		disease. The facility must d procedures to ensure that-				
	(i) Before offering th	ne pneumococcal				

		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		12/0	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAP	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	immunization, each representative rece benefits and potent immunization;	resident or the resident's ives education regarding the ial side effects of the	F 3:	34		
	immunization, unles	offered a pneumococcal ss the immunization is icated or the resident has nized;				
		the resident's representative to refuse immunization; and				
		nedical record includes indicates, at a minimum, the	C	$\mathbf{D}^{\mathbf{v}}$		
	was provided educa	nt or resident's representative ation regarding the benefits offects of pneumococcal				
	pneumococcal imm the pneumococcal i contraindication or This REQUIREMEN	nt either received the nunization or did not receive immunization due to medical refusal. NT is not met as evidenced				
	facility failed to impl Control and Preven to pneumococcal co 7 of 9 residents (F	v and document review, the lement the Center for Disease ition (CDC) guidelines related onjugate vaccine (PCV13) for R12, R1, R63, R24, R39, R29, ation histories were reviewed.		Nursing Dept. will, upon admission determine whether residents have received either of the pneumococca vaccines, and retrieve dates of administration if able. Vaccinations recorded in the residents record as historical, and will state whether the	al will be	
	Findings include:			vaccine received was PCV 23 or PC If either vaccine cannot be docume	CV13.	
		Control and Prevention (CDC) 5 years of age or older who		one or both vaccines as appropriate be offered and documented in the	ə, will	

Facility ID: 00758

If continuation sheet Page 39 of 50

TATEMEN	T OF DEFICIENCIES DF CORRECTION	A MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		0.1500.4				
		245304	B. WING _			01/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 300 NORTH DOW STREET	JODE	
THE GA	RDENS AT CANNON	FALLS		CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 334	have not previously red PPSV23 [pneumod 23] should receive PCV13 should be g receipt of the most R12's immunization indicated the 71 ye pneumococcal vac it did not indicate w current immunizatii failed to indicate su pneumococcal vac recommended by 0 R1's immunization indicated the 69 ye pneumococcal vac it did not indicate su pneumococcal vac recommended by 0 R63's immunization indicated the 74 ye pneumococcal vac did not indicate wh current immunizati indicate subsequer vaccine was offere CDC guidelines. R24's immunization indicated the 73 ye	y received PCV13 and who ceived one or more doses of coccal polysaccharide vaccine a dose of PCV13. The dose of given at least 1 year after recent PPSV23 dose." In record dated 12/1/16, ear old had received a ccination on 3/7/2007, however, which vaccine was given. The on record provided on 12/1/16, ubsequent dosing of the ccine was offered to R12 as CDC guidelines. record, dated 12/1/16, ear old had received a ccination on 7/1/2007, however, which vaccine was given. The on record provided on 12/1/16, ear old had received a ccination on 7/1/2007, however, which vaccine was given. The on record provided on 12/1/16, ubsequent dosing of ccine was offered to R1 as	F3		be offered d PCV 13 by s will be eeting on ng which both vaccines nented. MDS ccination status at completed (at late DON and inations are nmunization	

If continuation sheet Page 40 of 50

		AND HUMAN SERVICES				FORM	02/02/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245304	B. WING			12/01/2016		
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-		
THE GAR	RDENS AT CANNON F	ALLS			00 NORTH DOW STREET ANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 334	vaccine was offered guidelines. R39's immunization indicated the 99 yea pneumococcal vacc did not indicate whi The current immun to indicate subseque vaccine was offered guidelines. R29's immunization indicated the 75 yea pneumococcal vacc it did not indicate w The current immun to indicate subseque vaccine was offered guidelines. R60's immunization indicated the 71 yea pneumococcal vacc did not indicate whi The current immun to indicate subseque vaccine was offered guidelines. R60's immunization indicated the 71 yea pneumococcal vacc did not indicate whi The current immun to indicate subseque vaccine was offered guidelines. When interviewed of director of nursing ( aware of the current the pneumococcal vaccal confirmed resident!	ient dosing of pneumococcal d as recommended by CDC n record, dated 12/1/16, ar old had received a cination on 7/2/15, however it ch vaccine was given. ization record provided failed ient dosing of pneumococcal d as recommended by CDC n record, dated 12/1/16, ar old had received a cination on 10/25/10, however hich vaccine was given. ization record provided failed ient dosing of pneumococcal d as recommended by CDC n record, dated 12/1/16, ar old had received a cination on 9/26/15, however it ch vaccine was given. ization record provided failed ient dosing of pneumococcal d as recommended by CDC	F3	334				

If continuation sheet Page 41 of 50

		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		<u>0938-0391</u> E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COM	IPLETED
		245304	B. WING		12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID			ID			(X5) COMPLETION
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
			1			
F 334	Continued From pa	ge 41	F 334			
	A review of the facil	ity policy, titled Pneumococcal				
	Vaccine for the Sup	erior Healthcare Management				
		vas received. The policy is ned identified "All residents will				
	be offered pneumo	coccal vaccines to aid in				
		coccal infections. Number 7 of "Administration of the				
		cines or revaccination's will be e with current Centers For				
	Disease Control and	d Prevention (CDC)	•			
		at the time of the vaccination." licy indicated "Inquiries				
	concerning our facil	lity's policies governing sinations should be referred to				
	the Infection Prever	ntionist or Director of Nursing				
F 412	Services."	ROUTINE/EMERGENCY	E 412			1/10/17
SS=D	DENTAL SERVICE		1 412			1/10/17
	(b) Nursing Facilitie	s				
	The facility-					
		or obtain from an outside				
	part, the following d	ance with §483.70(g) of this ental services to meet the				
	needs of each resid	lent:				
	(i) Routine dental se under the State plan	ervices (to the extent covered n); and				
	(ii) Emergency dent	al services;				
	(b)(2) Must, if neces the resident-	ssary or if requested, assist				
	(i) In making appoi	ntments; and				

Facility ID: 00758

If continuation sheet Page 42 of 50

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM /	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		245304	B. WING		12/0	01/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	IDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa (ii) By arranging for dental services loca (b)(5) Must assist re wish to participate t dental services as a under the State plan This REQUIREMEN by: Based on observat review the facility fa for 1 of 3 residents routine dental service Findings include: R72 had been obse 11/29/16, at 2:30 p. several darkened ch throughout his mou	ge 42 transportation to and from the ations; esidents who are eligible and o apply for reimbursement of an incurred medical expense n. NT is not met as evidenced ion, interview and document iled to provide dental services (R72) reviewed who required	F 412	,	status DS 72 to /2017. er en se	
	abuse of methamph it was hard to chew chew regular texture texture. R72 stated swallowing. R72 fur seen by a dentist fo to have his teeth ex times. Review of R72's ad (MDS) assessment resident as having r cavity and did not in or decayed teeth. R quarterly MDS asse	to his long time substance hetamine. R72 further included , but indicated he would rather ed food than to adjust the he did not have problems with ther included he had not been r many years and would like amined, because they hurt at mission Minimum Data Set dated 8/18/16, identified the ho problems with his oral holude R72's chipped, missing review of the most recent essment dated 11/4/16, had no mouth pain, swallowing		agreement, or will be encouraged to an outside dentist if they choose no utilize in-house services as evidenc signed consent forms in resident re Social worker will document decline in-house services, and will monitor appointments and will update In-Ho Services monthly with new resident have chosen to use In-House Denta Services. Completion date 1-10-2017 Monitored by MDS Coordinator and Services	t to cords. of dental use s who al	

If continuation sheet Page 43 of 50

		AND HUMAN SERVICES				FORM	02/02/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	_	(X3) DATE	E SURVEY PLETED
		245304	B. WING			12/	01/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				300 NORTH DOW STREE	т		
THE GAR	RDENS AT CANNON F	ALLS		CANNON FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROP FICIENCY)	BE	(X5) COMPLETION DATE
F 412	Continued From pa or eating problems; at 185 pounds and set-up assistance. Review of the mos for R72 dated 11/1/ a regular diet and e Weight is stable at with swallowing. Th the condition of the Review of R72 's o 11/1/16, identified th having no problems refused to allow stat Review of R72's cu resident as being in set- up and receive eats independently obtain, record and u R72 eats 50 percer further indicated R7 brushes them indep not include nor add or decayed teeth. Interview with the fa 11/29/16, at 2:00 p. schedules needed of residents, indicated and desire for denta him seen by the on dentist conducted e	age 43 R72's weight has been stable brushes his own teeth after t current dietary assessment 16, indicated the resident is on eats 50 percent of his meals. 185 pounds . No problems the assessment did not include residents teeth. The assessment did not include residents oral cavity as a other than missing teeth, but aff to complete the exam. The dependent with eating after is a regular diet. Interventions: after set up assistance and monitor weights and fluids. It of his meals. The care plan 72 has natural teeth and bendently. The care plan did ress R72's chipped, missing acility social service director on m. who monitors and dental exams for the is she was aware of R72's need al services but failed to have site dentist. The on-site exams at the facility on	ıl				
		al service director indicated a had not been set up nor this time for B72					
F 441		e)(f) INFECTION CONTROL,	F4	441			12/27/16
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID:2C8411		Facility ID: 00758	If continuati	on sheet	Page 44 of 50

		AND HUMAN SERVICES			FORM	APPROVED
	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT	IPLE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		245304	B. WING _		10/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/	51/2010
				300 NORTH DOW STREET		
THE GAP	RDENS AT CANNON F	ALLS		CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION DATE
ina			inte	DEFICIENCY)		
_			1			
F 441	Continued From pa	-	F 44	1		
SS=F	PREVENT SPREA	D, LINENS				
	(a) Infection preven	tion and control program.				
		tablish an infection prevention				
		n (IPCP) that must include, at				
	a minimum, the foll	owing elements:				
		eventing, identifying, reporting,				
		ontrolling infections and				
		ases for all residents, staff, and other individuals				
	providing services ι	under a contractual				
		upon the facility assessment				
		ig to §483.70(e) and following tandards (facility assessment				
	implementation is F					
	(2) Mritton standar	ds, policies, and procedures				
	for the program, wh	hich must include, but are not				
	limited to:					
	(i) A system of surv	eillance designed to identify				
	possible communic	able diseases or infections				
		ead to other persons in the				
	facility;					
		om possible incidents of				
	communicable dise reported;	ase or infections should be				
		ansmission-based precautions event spread of infections;				
	(iv) When and how resident; including t	isolation should be used for a out not limited to:				
	(A) The type and du	uration of the isolation,				

If continuation sheet Page 45 of 50

AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COMPLET         AND PLAN OF CORRECTION       245304       B. WING       THEET ADDRESS, CITY, STRE, ZIP CODE         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STRE, ZIP CODE       SON MORTH DOW STREET       CANNON FALLS         Ora, ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDERS ACCANNON FALLS       STREET ADDRESS, CITY, STRE, ZIP CODE         Ora, ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDERS ACCANNON FALLS       STREET ADDRESS, CITY, STRE, ZIP CODE         Ora, ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDERS ACCANNON FALLS       STREET ADDRESS, CITY, STRE, ZIP CODE         OVER STREET       CANNON FALLS, MIN S5009       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDERS ACCANNON FALLS       ID         YEAR       SUMMARY STATEMENT OF DEFICIENCIES       ID       PREX       ID       PROVIDERS ACCANNON FALLS       ID         YEAR       GEAD EDFICIENCY       SUBLECAN EDFICIENCY       ID       ID <th></th> <th></th> <th>AND HUMAN SERVICES</th> <th></th> <th></th> <th></th> <th>FORM</th> <th>02/02/2017 APPROVED 0938-0391</th>			AND HUMAN SERVICES				FORM	02/02/2017 APPROVED 0938-0391	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       300 NORTH DOW STREET       CANNON FALLS     SUMMARY STATEMENT OF DEFICIENCIES     D       PREPIX     IEBOLATORY ON LSC DEFICIENCIES     D     PREPIX       REGULATORY ON LSC DEFICIENCY MINIFORMATION     PREPIX     PROVIDERS PLAN OF CORRECTION ECONOMIC DEFICIENCY     CONSENTER TO ADMINISTREET       TAG     SUMMARY STATEMENT OF DEFICIENCIES     D     PREPIX     PROVIDERS PLAN OF CORRECTION     CONSENTERT CANNON FALLS       F 441     Continued From page 45     Generation of the consent of the resident or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease; and     F 441       (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 provent the spread of infection.       (1) Annual review. The taglify will conductant annual review of its IPCP and update their program, as necessary.     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 infection to provent potential spread to others. This had potential to affect all spread to others. This had potential to affect all spread t							(X3) DATE SURVEY COMPLETED		
THE GARDENS AT CANNON FALLS       200 NORTH DOW STREET CANNON FALLS, MIN 5009       204 ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH OPRICENTY AN OF CORRECTION (EACH OPRICENTY AN OF CORRECTION (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 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.         (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.           (1) Annual review. The facility will conductant 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 the fa			245304	B. WING	à		12/0	01/2016	
THE GARDENS AT CANNON FALLS       CANNON FALLS, MN 55009         Image: Contract of the control control control of the control of the control contrelation of the control control control control control control con	NAME OF F	PROVIDER OR SUPPLIER					-		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CEACH ODERCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       CO         F 441       Continued From page 45 depending upon the infectious agent or organism involved, and       F 441       F 441         (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.       F 441         (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 with residents or their food, if direct contact with residents or their food, if direct contact with residents or the corrective actions taken by the facility.       F 441         (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.       The Director of Nursing and Infection Control Nurse will 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.	THE GAP	RDENS AT CANNON F	FALLS						
<ul> <li>depending upon the infectious agent or organism involved, and</li> <li>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</li> <li>(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</li> <li>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</li> <li>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</li> <li>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</li> <li>(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:</li> <li>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.</li> </ul>	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC	LD BE	(X5) COMPLETION DATE	
Findings include: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 beginningA binder was provided by registered nurse (RN)-Aof the infection control nurse beginning	F 441	depending upon the involved, and (B) A requirement t least restrictive pos- circumstances. (v) The circumstance must prohibit emplo disease or infected contact with resider contact with resider contact will transmi (vi) The hand hygie by staff involved in (4) A system for req under the facility's I actions taken by the (e) Linens. Person process, and transp spread of infection. (f) Annual review. annual review of its program, as necess This REQUIREMEN by: Based on interview facility failed to imp infection control pro- consistent tracking, illnesses and infect spread to others. T 56 residents, staff a Findings include:	e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct the disease; and ne procedures to be followed direct resident contact. cording incidents identified PCP and the corrective e facility. nel must handle, store, bort linens so as to prevent the The facility will conduct an IPCP and update their sary. NT is not met as evidenced v and document review, the lement a comprehensive bgram which included trending and analysis of ions to prevent potential this had potential to affect all and visitors to the facility.	F		Control Nurse will implement a tra log on each unit to track antimicro administration, lab cultures and d to improve the infection control co by 1/1/2017. Nursing will obtain r cultures which have been sent to analysis and report results on the log beginning 1/1/2017. A month tracking log will be maintained in	acking obial liseases orrelation results of lab for tracking ly the office		

Facility ID: 00758

If continuation sheet Page 46 of 50

		E & MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		E SURVEY PLETED
		245304	B. WING _			12/0	01/2016
NAME OF	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
THE GA	RDENS AT CANNON	FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 441	Continued From pa	age 46	F 44	11			
	the infection contro p.m. with different each specific mont monitoring. The foi identified: February 2016: An order listing rep residents who had month for different cellulitis, pneumon (UTI). The report la consistent docume infection was deter in-house acquired. The collected data the infections in the cause of each infect or were spreading There was no furth March 2016: An order listing rep received antibiotics the month for differ urinary tract infection yeast. The report la organism cultures determined to be c acquired.	ort identified nine different received antibiotics during the diagnoses which included ia and urinary tract infections acked room numbers, entation of organism, or if the mined to be community or lacked trending or analysis of e facility to determine the ction or if they had potential to in the facility. her provided information.			the month of January, 2017; comp will be monitored through the use monthly tracking log. The evening manger will review the unit logs w completion, copy and give to the in control nurse beginning 1/1/2017. nurses will be educated on proced review policy at the nursing meeting 1/4/2017 Completion date 12-28-2016 Monitored by Director of Nursing a Infection Control Nurses	of the y Nurse eekly for nfection Staff lure and ng on	

If continuation sheet Page 47 of 50

		AND HUMAN SERVICES					FORM	02/02/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATI	E SURVEY PLETED
		245304	B. WING	i			12/	01/2016
NAME OF I	PROVIDER OR SUPPLIER	•	-	5	STREET ADDRESS, CITY, STATE,	ZIP CODE		
THE GAI	RDENS AT CANNON F	FALLS			300 NORTH DOW STREET CANNON FALLS, MN 55009	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 441	mg daily for 7 days identified type of inf documented on the "? infection" listed w documented on the treated with Levaqu days. The collected data the infections in the cause of each infect or were spreading i There was no furthe April 2016: An order listing rep where residents ha the month. Two of t documented, the of lacked any room nu documentation of o resolution or if the i community or in-ho The collected data the infections in the cause of each infect or were spreading i There was no furthe May 2016: An order listing rep where residents ha	as treated with Levaquin 500 for prophylaxis without an fection or culture results report. Another resident had with not culture results report. This resident was in 500 mg by mouth daily for 5 lacked trending or analysis of facility to determine the ction or if they had potential to n the facility. er provided information. ort identified 12 infections d received antibiotics during the 12 had sites of infection thers were blank. The report umbers, type of infection, any rganism, consistent date of nfection was determined to be use acquired. lacked trending or analysis of e facility to determine the ction or if they had potential to	F	441				

If continuation sheet Page 48 of 50

		AND HUMAN SERVICES			FORM	: 02/02/2017 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245304	B. WING		12/	/01/2016
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GA	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	lacked any room nu documentation of o resolution or if the i community or in-ho The collected data the infections in the cause of each infect or were spreading i There was no furthe June 2016: An order listing repo- where residents ha were documented s detail related to the Nystatin. The repor resolution or if the i community or in-ho The collected data the infections in the cause of each infect or were spreading i There was no furthe July 2016: An order listing repo- where residents ha were no documente lacked room numb documentation of o	hers were blank. The report umbers, type of infection, any rganism, consistent date of infection was determined to be use acquired. lacked trending or analysis of efacility to determine the stion or if they had potential to in the facility. er provided information. ort identified 18 infections d received antibiotics. There sites of infection and more use of Bactroban, and t lacked consistent date of infection was determined to be use acquired. lacked trending or analysis of efacility to determine the stion or if they had potential to in the facility. er provided information. ort identified 6 infections d received antibiotics. There ed sites of infection. The report ers, type of infection, any rganism, consistent date of infection was determined to be	F 44			

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
			/				
		245304	B. WING			12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAP	RDENS AT CANNON F	FALLS			00 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	V	(X5)
PRÉFIX	(EACH DEFICIENCY	( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION DATE
TAG	HEGGERIOITI OITE		TAG		DEFICIENCY)		
F 441	Continued From pa	ge 49	F 4	141			
	The collected data	lacked trending or analysis of					
		facility to determine the					
		tion or if they had potential to					
	or were spreading i	n the facility.					
	There was no furthe	er provided information.					
		, October and November					
	2016:						
	No order listing rep	ort was provided.					
		on 12/1/16, at 12:52 p.m. the					
		(DON) confirmed the past four					
		dn't exist. When asked about dship program, the DON was					
	not aware of it and	had not implemented anything					
		reeducation. Further, the ection control program lacked	Ť				
		ng, trending or analysis of the					
	collected data, addi	ing "We have to enhance our					
	program."						
	During the interview	v, the DON stated infections					
		heir Monday through Friday					
	for tracking or trend	here was not any processes					
	for tracking of treffe	ang.					
		licy was requested but not					
	received.						
1			1				

Facility ID: 00758

If continuation sheet Page 50 of 50

# **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building				
245304 <sub>Y1</sub>	B. Wing	Y	Y2	1/19/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GARDENS AT CANNON F	ALLS	300 NORTH DOW STREET			
		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).

ITE	Μ	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	F0166	Correction	n ID Prefix	F0241	Correction	ID Prefix	F0242		Correction
Reg. #	483.10(j)(2)-(4)	Complete	d Reg. #	483.10(a)(1)	Completed	Reg. #	483.10(f)(1)-(3)		Completed
LSC		01/10/2017	LSC		01/10/2017	LSC			01/10/2017
ID Prefix	F0278	Correction	n ID Prefix	F0279	Correction	ID Prefix	F0282		Correction
Reg. #	483.20(g)-(j)	Complete	d Reg. #	483.20(d); <b>483</b> .2	21(b)(1) Completed	Reg. #	483.21(b)(3)(ii)		Completed
LSC		01/10/2017	LSC		01/10/2017	LSC			01/10/2017
ID Prefix	F0285	Correction	n ID Prefix	F0309	Correction	ID Prefix	F0312		Correction
Reg. #	483.20(e)(k)(1)-	Complete	d Reg.#	<b>483.24</b> , <b>4</b> 83.25	(k)(l) Completed	Reg. #	483.24(a)(2)		Completed
LSC		01/10/2017	LSC		01/10/2017	LSC			01/10/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	483.55(b)(1)(2)	(5) Complete	d Reg. #		Completed	Reg. #			Completed
LSC		01/10/2017	LSC			LSC			
ID Prefix		Correction	n ID Prefix		Correction	ID Prefix			Correction
Reg. #		Complete	d Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
REVIEWE STATE A		REVIEWED BY (INITIALS) GPN/k	fd 2/2/20		TURE OF SURVEYOR	37476		<b>DATE</b> 1/19/	2017
REVIEWE CMS RO	ED BY	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?					

DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAII	) CERTIFICA	TION A	AND TRANSMITTAL	ID: 2C84
	PART I -	TO BE COMPL	ETED BY TH	E STAT	TE SURVEY AGENCY	Facility ID: 00758
1. MEDICARE/MEDICAID PROVI	DER	3. NAME AND AD			a	4. TYPE OF ACTION: <u>2</u> (L8)
NO.(L1) 245304		(L3) THE GARDI			28	1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAI (L2) 847972200	D NO.	(L4) 300 NORTH (L5) CANNON FA			(L6) <b>55009</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
<ol> <li>5. EFFECTIVE DATE CHANGE OF (L9) 12/20/2013</li> </ol>	FOWNERSHIP	7. PROVIDER/SUI		RY 09 <b>ESRD</b>	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
	/01/2016 <sup>(L34)</sup>	02 SNF/NF/Dual		10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray 1	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATIO	ON	10.THE FACILITY	IS CERTIFIED AS	S:		
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program Re Compliance			2. Technical Personnel	6. Scope of Services Limit
		-			3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	74 (L18)	<b>X I</b> . Ac	cceptable POC		4. 7-Day RN (Rural SN	—
13.Total Certified Beds	<b>74</b> (L17)		pliance with Program	m	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied Wai	ivers:	* Code: B	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
74						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REP     17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Michelle Jaeckels,	HFE NE II	0	1/09/2017	(1.10)	Kamala Fiske-Downing,	, Enforcement Specialist 01/26/2017
PA	ART II - TO BE	COMPLETED B	SY HCFA REG	(L19) GIONAL	OFFICE OR SINGLE S	(L20) TATE AGENCY
19. DETERMINATION OF ELIGIB	ILITY	20. COM	PLIANCE WITH C	CIVIL	21. 1. Statement of Finan	ncial Solvency (HCFA-2572)
<ol> <li>Facility is Eligible to</li> </ol>	Participate	RIGH	TS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	bl Interest Disclosure Stmt (HCFA-1513)
<ul> <li>2. Facility is not Eligib</li> </ul>	-				5. Bour of the Above	
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNINC	6 DATE	ENDING DATE		VOLUNTARY 00	INVOLUNTARY
02/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	oo Fuir to Frieder Egitement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	P. Passind St	uspension Date:	(L44)			00-Active
	D. Resellid St	ispension Date.	(1.45)			
28. TERMINATION DATE:	20	. INTERMEDIARY/0	(L45)		30. REMARKS	
20. TERMINATION DATE.	25		CARRIER NO.		50. REMARKS	
	(1.28)	00270		(1.21)		
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	ATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



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:

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

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

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

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

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

The Gardens At Cannon Falls December 16, 2016 Page 2

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.

The Gardens At Cannon Falls December 16, 2016 Page 3

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: The Gardens At Cannon Falls December 16, 2016 Page 5

> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

DEPAR	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245304	B. WING			12/	01/2016
NAME OF	PROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAI	RDENS AT CANNON H	FALLS			00 NORTH DOW STREET ANNON FALLS, MN 55009		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	COMPLETION DATE
F 000	INITIAL COMMEN	ſS	FC	00			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verification Upon receipt of an on-site revisit of you validate that substat regulations has been	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with					
	complaint investiga the time of the stan An investigation of	rvey was conducted and tion(s) were also completed at dard survey." complaints H5304036 were mplaint was substantiated at					
F 166 SS=D	completed during th substantiated. An investigation of completed during th substantiated. 483.10(j)(2)-(4) RIC TO RESOLVE GRI (j)(2) The resident h must make prompt	has the right to and the facility efforts by the facility to resolve dent may have, in accordance	F 1	66			1/10/17
	y DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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.

		AND HUMAN SERVICES				FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245304	B. WING			12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON F	ALLS			00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	Continued From pa	ge 1	F 1	66			
		ust make information on how or complaint available to the					
	to ensure the prompregarding the resider paragraph. Upon re	ust establish a grievance policy pt resolution of all grievances ents' rights contained in this equest, the provider must give ance policy to the resident. The ust include:					
	postings in promine facility of the right to (meaning spoken) of grievances anonym of the grievance off can be filed, that is, address (mailing ar number; a reasonal completing the revie to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvement Agency and State L program or protection	t individually or through ent locations throughout the o file grievances orally or in writing; the right to file nously; the contact information icial with whom a grievance , his or her name, business nd email) and business phone ble expected time frame for ew of the grievance; the right decision regarding his or her contact information of s with whom grievances may pertinent State agency, nt Organization, State Survey Long-Term Care Ombudsman on and advocacy system;					
	responsible for over receiving and tracking conclusions; leading by the facility; main information associate example, the identiti	evance Official who is rseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all ated with grievances, for ty of the resident for those ed anonymously, issuing					

Facility ID: 00758

If continuation sheet Page 2 of 52

		AND HUMAN SERVICES			FORM	01/18/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245304	B. WING		12/01/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
THE GAI	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 166	Continued From pa	-	F 166	5			
	coordinating with st	ecisions to the resident; and ate and federal agencies as f specific allegations;					
	prevent further pote	aking immediate action to ential violations of any resident ed violation is being					
	reporting all alleged abuse, including inj and/or misappropria anyone furnishing s	§483.12(c)(1), immediately d violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and e law;					
	include the date the summary statemen the steps taken to in summary of the per regarding the reside as to whether the g confirmed, any corr taken by the facility	written grievance decisions e grievance was received, a t of the resident's grievance, nvestigate the grievance, a rtinent findings or conclusions ent's concerns(s), a statement rievance was confirmed or not rective action taken or to be as a result of the grievance, itten decision was issued;					
	accordance with St of the residents' rig or if an outside enti- the State Survey Ag Organization, or loc confirms a violation rights within its area	ate corrective action in ate law if the alleged violation hts is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement cal law enforcement agency for any of these residents' a of responsibility; and dence demonstrating the					

If continuation sheet Page 3 of 52

		AND HUMAN SERVICES			I	FORM /	01/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (>	(X3) DATE SURVEY COMPLETED	
		245304	B. WING			12/0	01/2016
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
THE GAR	RDENS AT CANNON F	FALLS			00 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 166	3 years from the iss decision. This REQUIREMEN by: Based on interview facility failed to ens a complaint grievar electric razor for 1 of for missing persona Findings include: R34's quarterly Mini identified a Brief Int of 13 (cognitively in During interview on stated he had been about two weeks, a looking for it. Altho nursing assistant st him. During interview on social worker (SW) form filled out on an SW-A further stated should fill them out lost something and provided the missin nine month period a two reports. Neither razor. During interview on registered nurse (R R34 was missing a	v and document review, the ure follow-up investigation into nce in regards to missing of 2 residents (R34) reviewed al property.	F 1	66	R34's family has been notified, and a purchasing a new razor for the reside The facility has drafted a new policy a procedure on the filing of grievances will present it to all residents and fam upon admission. It will be presented next resident council meeting. The residents' families will be mailed copi the new resident grievance and lost i forms. These forms are also now inc in the admissions packets. All grieva will be tracked and monitored weekly Families and residents will be notified findings. This will be monitored by the Director Social Service and will be completed 1-1-2017	ent. and and nilies at the nies of items cluded unces y. d of r of	

If continuation sheet Page 4 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245304	B. WING			12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON F	ALLS		-	800 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 166 F 241 SS=D	to social services. for Veteran's Day a then. During interview on licensed practical n aware activities had ago and now it was the date she had be During interview on activities director (A brand new razor he happened within the she had wanted to however did not had last time she went of stated it was on her date. The AD was n reports filled out for The facility policy en undated, stated res missing items must Nursing Services, a or mistreatment of immediately investing 483.10(a)(1) DIGNI INDIVIDUALITY (a)(1) A facility must resident in a manner promotes maintena	the missing item and turn it in RN-B stated R34 was shaved ind would likely have had it 11/30/16, at 11:20 a.m. urse (LPN)-A stated she was d given R34 a razor a while missing, but could not state een informed it was gone. 11/30/16, at 11:31 a.m. the AD) stated R34 was missing a had gotten and that it had e last month. The AD stated purchase R34 a new one, ve the funds in her budget the on a shopping trip. The AD r list to purchase at a future not aware of any missing item the razor. ntitled Lost and Found, ident or family complaints of be reported to the Director of and reports of misappropriation resident property are		166			1/10/17
	promote the rights of	cility must protect and of the resident. NT is not met as evidenced					

Facility ID: 00758

If continuation sheet Page 5 of 52

					OMB NO.	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245304	B. WING _		12/	01/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
THE GAI	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 241	review, the facility fa environment for 1 o for dignity whose ur and catheter bag we uncovered in her ro Findings include: R42's face sheet, d diagnoses of parap R42's annual Minim identified a Brief Int of 15 (cognitively in During interview on stated she was not and dignity. R42 inc catheter bag being incontinence produc entering the room to visualized at this tim her bed, uncovered A box of gloves and sitting on top of her stated she rarely go pressure ulcer on h frequent repositioni	ion, interview and document ailed to ensure a dignified f 1 resident (R42) reviewed inary incontinence supplies ere left exposed and om. ated 12/1/16 identified legia and urinary retention. um Data Set, dated 9/23/16 erview for Mental Status score tact). 11/28/16, at 5:43 p.m. R42 always treated with respect licated she did not like her left uncovered and her cts being left out for anyone o see. R42's catheter bag was ne to be hanging on the end of with urine present in the bag. I incontinence wipes was bedside stand. R42 further of out of bed due to having a er bottom that required ng. on 11/30/16, at 3:51 p.m.	F 24		Manager, ew care rder in PCC th catheters red every with d to PCC will be Nurse nence of view of catheter are not g minutes ing resident	
	R42's catheter bag draining into the bay was lying out on he During observation was assisted with m	was uncovered with urine g and an incontinence pad				

If continuation sheet Page 6 of 52

	-	AND HUMAN SERVICES			FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245304	B. WING		12/	01/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GA	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	R42 with washing th applying a clean go and providing incon Licensed practical r complete wound ca 10:54 a.m., R42's n and all staff exited F pad was lying on R4 some gloves, and h exposed without a co of her bed. Dark an bag. During interview on stated it bothered h left out and incontin bedside stand, as s up herself. R42 stat her room would be she had bowel and not feel she should them up. During interview on nurse (RN)-B stated R42's catheter bag was out of the room RN-B confirmed tha left out was undigni During interview on director of nursing ( products should not but stated as long a face the hallway it m	he top half of her body, then hwn and washing her lower half ntinence care. At 10:37 a.m., hurse (LPN)-A proceeded to the on R42's pressure ulcer. At norning cares were completed R42's room. An incontinence 42's bedside stand along with her urinary catheter was cover on it, hanging at the end inber urine was present in the 12/01/16, at 11:13 a.m. R42 her that the catheter bag was hence supplies were on her she was unable to pick them ted anyone who stopped by able to see them and know bladder issues, and she did have to remind staff to pick 12/1/16, at 11:24 registered d she would have expected be covered whenever she h, but not necessarily in bed. at incontinence products being fied. 2/1/16, at 11:23 a.m. the (DON) stated that incontinence t be left out in resident rooms, as a urinary catheter bag didn't night be okay.	F 241			

If continuation sheet Page 7 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245304	B. WING	i		12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	_	
THE GAP	RDENS AT CANNON F	ALLS			00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242 SS=D	483.10(f)(1)-(3) SE RIGHT TO MAKE (	LF-DETERMINATION - CHOICES	F:	242			1/10/17
	schedules (includin health care and pro- consistent with his of and plan of care an of this part. (f)(2) The resident H about aspects of his are significant to the (f)(3) The resident H members of the con- community activitie facility. This REQUIREMEN by: Based on interview facility failed to ens R11) reviewed for co- according to their p frequency. Findings include: R42's face sheet, d diagnoses of parap	has a right to interact with mmunity and participate in s both inside and outside the NT is not met as evidenced and document review, the ure 2 of 3 residents (R42 & hoices received baths references for bathing ated 12/1/16 identified a legia and urinary retention.			Admission assessment updated to include questions of preference of bath/shower, time (day/evening) for weekly bath /shower. Extra weekly bath/showers can be accommodate based on staff scheduling. Review bath/shower schedule by DON/Nur Managers monthly to ensure consis of bath schedule on Kardex and in plan.	r of se stency care	
	9/23/16 indicated a Status (BIMS) score R42's care area as of daily living (ADL) R42 was totally dep	num Data Set (MDS), dated Brief Interview for Mental e of 15 (cognitively intact). sessment (CAA) for activities , printed 12/1/16 indicated bendent upon staff in all ADL priented. Proceed to care plan level of functioning.			Nurse meeting agenda on 1/4/2017 included education of documenting bath/shower body audit and refusal Nurse Manager to conduct weekly on Refusal to ensure body audits a completed and documentation of b given and or refused. Bath audit assessment updated to include nur documentation of bath/shower give	ls. audits re aths rse	

Facility ID: 00758

If continuation sheet Page 8 of 52

		AND HUMAN SERVICES				FORM	APPROVED
							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
			A. DOILDI	<u>.</u>			
		245304	B. WING _			12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,                                     </u>	
	RDENS AT CANNON F			30	00 NORTH DOW STREET		
	IDENS AT CANNON P	ALLS		С	ANNON FALLS, MN 55009		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETION DATE
					DEFICIENCY)		
_							
F 242	Continued From pa	ge 8	F 24	42			
					refused.		
		ted 12/1/16 indicated R42 of two staff for bathing and					
		d bath weekly and as needed					
	(PRN).	,					
	D40la annaisan a dari						
		ssion assessment, dated ify how often R42 preferred a					
	bath.	ily new onen nitz preferred a					
		11/28/16, at 5:42 p.m. R42					
		bathed according to her Id not been asked how often					
		th, and receiving extra baths					
	was "not encourage	ed." R42 stated she was trying					
		o on her hair and did not					
	always even get he	r hair brushed on a daily basis.					
	During follow up int	erview on 12/1/16, at 10:12					
	a.m. R42 stated she	e would like a bath a couple of					
		ossible, however she was					
		If time for the staff. R42 she was told this would be an					
	0	point during her stay.					
	ontia ontaigo at onto						
		12/1/16, at approximately					
		I worker (SW)-A indicated all ed about bathing frequency on					
		sing assessment, any					
		uch should be included on this					
	form.						
		view on 11/30/16, at 11:38					
		dicated she had not had a weeks. R11 included she					
		ere too busy to give her a bath					
	during these times.	R11 further included she					
	would like a bath at	least weekly.					
	Review of the curre	nt quarterly Minimum Data					

If continuation sheet Page 9 of 52

		AND HUMAN SERVICES				FORM	APPROVED
	AS FOR MEDICARE						0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
			A. BOILDI				
		245304	B. WING			12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GAF	RDENS AT CANNON F	ALLS		-	00 NORTH DOW STREET		
				(	CANNON FALLS, MN 55009		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	~	CROSS-REFERENCED TO THE APPROP		DATE
			1		DEFICIENCY)		
F 242	Continued From no	~~ 0	Го	40			
1 272	Continued From pa	0/28/16, indicated R11's	F 2	42			
		ur during this assessment					
		s 1 assistance with bathing.					
		interview for mental status					
	BIMS score was 15 is intact).	out of 15 (meaning cognition					
	is intact).						
		current plan of care for R11,					
		nt as having an activities of					
		e deficit related to being easily ecrease, history of falls,					
		and atrophy. Interventions;					
	requires 2 assistant	ce with bathing, washing and					
	transfers. Staff to w	ash hair and do nail care.					
	Review of the week	ly bathing sheets for the past					
		11 received a bath on					
		nd 11/12/16, but did not					
	include bathing for 11/26/16.	the weeks of 11/19/16 or					
	11/20/10.						
	Interview with the fa	acility MDS coordinator on					
		a.m. confirmed R11 did not					
		ng the MDS quarterly					
		dated 10/28/16. The MDS sluded that she had not not					
		by the resident did not receive					
	a bath during this til						
	Interview with region	tered nurse (RN)-B a nurse					
		16, at 1:35 a.m. confirmed					
		nentation that R11 had					
		he past 2 weeks. She also					
	confirmed R11's ski not been completed	in checks during bathing had					
	not been completed	1 43 WEII.					
		ng assistants (NA)-C, NA-D					
		/16, at 1:43 p.m. indicated they					
	were primary careg	ivers for R11's wing and					

Facility ID: 00758

If continuation sheet Page 10 of 52

		AND HUMAN SERVICES			FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245304	B. WING		12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GAP	RDENS AT CANNON F	FALLS		00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	Continued From pa	uge 10	F 242			
		lent receives a weekly bath on ld not verify a bath had been				
F 243 SS=E	was provided.	Dathing was requested, none 6)(7) RIGHT TO PARTICIPATE 11LY GROUP	F 243			1/10/17
		has a right to organize and ent groups in the facility.				
	group, if one exists reasonable steps, v to make residents a	provide a resident or family , with private space; and take with the approval of the group, and family members aware of s in a timely manner.				
		r other guests may attend amily group meetings only at p's invitation.				
	person who is appr group and the facili providing assistanc	t provide a designated staff oved by the resident or family ty and who is responsible for e and responding to written t from group meetings.				
	(f)(6) The resident h family groups.	has a right to participate in				
	member(s) or other meet in the facility v representative(s) of	has a right to have family r resident representative(s) with the families or resident f other residents in the facility. NT is not met as evidenced				
		tion, interview and document		The facility staff will adhere to the		

Facility ID: 00758

If continuation sheet Page 11 of 52

			()(0)				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	PLETED
		245304	B. WING _	à		12/01/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	DENS AT CANNON	FALLS			00 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 243	Continued From p	-	F 24	13			
		ailed to allow the resident			decision of the resident council reg		
		vately without staff in resident council meetings			attendance at Resident Council me A staff person will take minutes of t		
					council proceedings only if request	ed by	
	Findings include:				the Resident council. Residents wil on whether they wish for staff to be		
	R40 had been inte	rviewed on 11/30/16, at 9:00			present. Staff will continue to take		
	a.m. as she was d	esignated council president.			on a monthly basis until the resider	nt	
		resident council meets on a			council votes that they do not wish		
		that she leads the meetings lity activity director. R40			person to take minutes. Manageme will continue to be present by invita		
		ity director takes notes and will			only as is the current practice.		
		sions/concerns that the			The Executive Director or his desig		
		e. R40 further included that the as not had the option to meet			will monitor compliance by reviewir minutes and attendance of the Res		
		cated she has suggested to the			Council meetings within 5 business		
	activity director in t	the past when she had a			after each meeting of the Resident		
		rivately during the resident			Council to ensure that approval has		
		40 indicated the activity er she needed to stay for the			given by the Resident Council for a visiting staff members, and to ensure		
		ake notes on everything that is			continued compliance with the prog	gram.	
		ated there was a resident			This audit will be a continuous audi		
		n 12/1/16, and she was going to ity directors attention again.			Executive Director will report the re this audit to the QA Committee more		
	Observation of the	resident council meeting on			Completion date 1-1-2017		
	12/1/16, at 2:30 p.	m. R40 asked the activity					
		Id leave the room during their					
		ncil wanted to talk privately. or indicated she needed to stay					
	to take notes so th	ey could be discussed with the					
		d that there would have to be a					
		d take place. The activity his concern could be discussed					
	at a later date.						
		activity director on 12/2/16, at					
	10:23 a.m. confirm			1			

If continuation sheet Page 12 of 52

	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MELTIE		NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		245304	B. WING		12/01/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE GAR	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE
F 243	Continued From pa	ae 12	F 243	3	
	requested. She fur know this was a ch	her indicated that she did not oice for the residents and that eded to stay to take notes.			
F 253 SS=E	council but none pr	sted concerning resident ovided. EKEEPING & MAINTENANCE	F 253	3	1/10/17
	necessary to maint comfortable interior This REQUIREMEI by: Based on observa review, the facility f sanitary environme repair, for residents	NT is not met as evidenced tion, interview, and document ailed to maintain a clean, nt, and resident rooms in good s, staff and visitors. This had		Carpet odor in 200 wing: Entire length the hall was cleaned and disinfected. Housekeeping and Maintenance will monitor on a daily basis and clean are	
	hundred wing. Findings include:	ct 12 residents on the two		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	
	Observations noted 11/28/16, and verifi	d during the initial tour on ed on 12/1/16, at 12:50 p.m. ntal director (ED) were as		the hallways and change residents wh may have soiled clothing. Rooms are cleaned daily and those rooms with od issues will be checked more than daily ensure odors are maintained at an acceptable level.	ors
	strong pungent odd	ur on 11/28/16 at 2:48 p.m., a or was present in the hallway es station on the 200 wing.		R13 wheelchair and R35 wheelchair w cleaned. A policy and procedure for cleaning wheelchairs will be developed and implemented. The policy will requi	1
	surveyor "the carpe unbearable, especi	B p.m. R42 complained to the st smells of pee, and becomes ally in the summer, they know		the nursing staff to notify the housekeeping staff when a wheelchair in need of cleaning. Nursing will label t	is he
		to telling staff of the smell]." t odor of urine in the hall by the		wheelchair with the resident's name ar take it to the housekeeping departmen where it will be cleaned and then return	t

Facility ID: 00758

If continuation sheet Page 13 of 52

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	T		OMB NO.	APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		12/	01/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GA	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 253	200 wing, was note 11/28/16 at 2:48 p.1 11/30/16 at 2:48 p.1 On 11/30/16 10:47 that the carpet was length of the 200 has the door strips to the debris. Hallway car large white stain. F located directly outs R13's wheelchair w substance that app in the foot pedals, k the chair upholstery R35's wheelchair w debris, the foot plat dried on food and c R81 was interviewe and stated, "I feel the bedroom floor was puddles of a brown revealed surface da wax surface was un faucet was leaking orange across the borownish red all alco	also outside of rooms on the ad during the survey on m., 11/30/16 at 10:47 a.m., m., and 12/1/16 at 10:15 a.m. a.m. an observation revealed soiled heavily with debris the allway with multiple stains, also be rooms had grime, dirt and pet located outside R23 had a ood debris was observed to be side of R4's room. vas observed to be soiled, a eared to be nuts was built up prown debris was visible and y felt sticky to the touch. vas observed to be soiled with debris. ed on 11/29/16 at 10:51 a.m., hat my room is filthy." R81's observed to have dry and wet n amber liquid. The floor amage, the appearance in the neven. In R81's bathroom the and the sink had stained rusty bowl. The tile is stained ong the outside edges	F 25	<ul> <li>to the nursing department. Nursimonitor this daily.</li> <li>R81 sink and stool were cleaned gaskets have been installed. Floc cleaned. All bathrooms are cleaned daily basis and housekeeping with maintenance of repairs which ne conducted to ensure that broker are repaired and missing items are repaired. Monitored by housekee maintenance daily.</li> <li>R34 privacy curtain was replace were patched, sanded and paint Nursing, housekeeping and mai staff will check rooms daily and random basis for torn or soiled of and privacy curtains. When a rovacant, housekeeping does a decleaning and replaces the privace curtains.</li> <li>R4 walls were patched, sanded painted and ceiling tile was replaced inform maintenance by writing n repairs in the maintenance log of nursing station.</li> <li>R35 ceiling tile was replaced.</li> <li>Housekeeping, maintenance an will monitor for ceiling tile repairs</li> </ul>	d and new or was ned on a ill notify eed to be items are eping and d, walls ed. ntenance on a surtains om is eep sy and aced. will in a daily repair and eeded n each d nursing s and note		
	wax surface was un faucet was leaking orange across the brownish red all alc extending 6-8 inche R81 stated, "It is ea a new seal, I don't I The bathroom also	neven. In R81's bathroom the and the sink had stained rusty bowl. The tile is stained		nursing station. R35 ceiling tile was replaced. Housekeeping, maintenance an	d nursing s and note nursing eded enance coms a daily epaired or		

Facility ID: 00758

STATEMENT		KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	( )	E SURVEY PLETED
IND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED
		245304	B. WING _			01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
THE GAP	RDENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 253	Continued From pa	age 14	F 25	53		
	mopped the room to recently had a deep there is a strong un On 11/30/16 at 2:30 soiled and stained substance 4 feet of heavily scraped with damage behind the On 11/29/16 at 11: R4, the ceiling tile in and bowing away for register is located. have patches of pla There is a 2 inch pla On 11/28/16 at 6:13 interview with R35, observed in the bath During a interview of p.m. 5 inch strips of missing from the with On 11/28/16 at 4:44 R 72, the bathroom wall is damaged, with states that he notified On 11/28/16 at 4:44 been found to be signed	0 p.m. R34 privacy curtain is with a reddish brown color ff of the floor. The walls were th missing paint and surface e chair and the bed. 16 a.m. during a interview with s observed to be discolored, rom the strip where the heat The walls in the bathroom aster, they are not painted. iece of ceiling tile missing. 3 p.m. during the initial cracked ceiling tile is throom. with R15 on 11/28/16 at 6:49 f blinds are observed to be		maintenance logs on each r to notify maintenance of new replacements. Wall paper in the 200 wing I patched and repaired where board was exposed. All built and rooms where wallpaper surface will be monitored by housekeeping and and main daily basis as they work thro building. Existing damage to patched and painted. Monitored by Maintenance, and Administration	eded repairs or nallway was the wall ding hallways is on the ntenance on a oughout the o walls will be	
		0 p.m. Wall paper in the pom 217-219, and				

If continuation sheet Page 15 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245304	B. WING		12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	multiple areas revea On 12/1/16 at 12:30 was a 5 inch x 16 for wall, ceiling tiles we missing. There is a the wall is damaged through out revealin below. There was a but had not been so During the tour on the verified the houseker room and bathroom carpet should be re- discussed in a mee The ED stated the h staff were responsil were needed. When presented a clip boo communication, wh issues in need of re- the communication A policy for building on 12/1/16 at 2:00 p	I multiple torn/scraped off in aling the wallboard below. D p.m. in the dining room there bot long black mark along the ere noted to have pieces 18 inch by 4 foot area where d. The wall paper was missing ing a damaged wall board thick layer of plaster applied moothed nor painted. 12/1/16 at 1:30 p.m., the ED eeping staff cleaned each in daily. He confirmed that the placed and that it was ting, but not budget approved. nousekeepers and nursing ble to report when repairs in in the 200 wing the ED ard that was used for en there were environmental ispair. There were no notes on board. maintenance was requested o.m. The ED presented a	F 25	3		
F 278 SS=D	unaware of a policy 483.20(g)-(j) ASSE		F 27	8		1/10/17
	must accurately ref	essments. The assessment lect the resident's status. must conduct or coordinate <i>v</i> ith the appropriate				

Facility ID: 00758

If continuation sheet Page 16 of 52

		AND HUMAN SERVICES			FORM	01/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245304	B. WING _		12/0	01/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	the assessment is (2) Each individual	Ith professionals. The must sign and certify that completed. Who completes a portion of the sign and certify the accuracy of	F 2'	78		
	who willfully and kn (i) Certifies a mater resident assessme	and Medicaid, an individual				
	and false statemen subject to a civil mo \$5,000 for each as (2) Clinical disagree material and false s	ement does not constitute a				
	by: Based on observat review, the facility f Minimum Data Set	tion, interview and document ailed to accurately code the (MDS) assessment for 1 of 1 ewed for oral/ nutritional		A modification of the 14 day MI was submitted the day it was no survey team. The MDS Coordin review and check all the section MDS For accuracy of other dep entries and confirm the informa the care plan with each MDS (a quarterly). Completion date 1-10-2017 Monitored by the MDS Coordina	oted by the hator will of the hartments tion with t least	

Facility ID: 00758

If continuation sheet Page 17 of 52

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		TE SURVEY
		IDENTIFICATION NONDER.	A. BUILDING		001	
		245304	B. WING		12	/01/2016
	PROVIDER OR SUPPLIER	FALLS	3	BTREET ADDRESS, CITY, STATE, ZIP CODE 100 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 278 F 279 SS=D	resident as having R45's MDS 14 day identified the reside and mechanically a During an observat R45 was observed independently hot of breakfast tray with located on the tray. When interviewed of dietary manager (D feeding tube and co coding on the MDS 483.20(d);483.21(b COMPREHENSIVE 483.20 (d) Use. A facility r assessments comp months in the resid results of the asses and revise the resid plan. 483.21 (b) Comprehensive each resident, cons set forth at §483.10 includes measurab to meet a resident's	a mechanically altered diet. assessment dated 10/19/16, ent as having tube feedings altered diet. ion on 11/29/16, at 8:59 a.m. to be feeding herself batmeal cereal and had a other regular foods and liquids on 11/30/16, at 2:00 p.m. the PM) verified R45 never had a confirmed it was an inaccurate of dated 10/19/16. PM) DEVELOP E CARE PLANS nust maintain all resident bleted within the previous 15 lent's active record and use the assments to develop, review dent's comprehensive care	F 278			1/10/17

If continuation sheet Page 18 of 52

		AND HUMAN SERVICES			FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245304	B. WING		12/(	01/2016
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GAP	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Continued From pa care plan must des (i) The services tha or maintain the resi physical, mental, ar required under §48 (ii) Any services tha under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative servic provide as a result recommendations. findings of the PAS, rationale in the resid (iv) In consultation w resident's represen (A) The resident's g desired outcomes. (B) The resident's p future discharge. Fa whether the resider community was ass local contact agenc entities, for this pur (C) Discharge plans	Age 18 acribe the following - tt are to be furnished to attain ident's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not a resident's exercise of rights luding the right to refuse 83.10(c)(6). I services or specialized tes the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate pose. s in the comprehensive care		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
	requirements set fo section.	e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced				

If continuation sheet Page 19 of 52

	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		0938-039 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		G	COM	PLETED
		245304	B. WING		12/	01/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 279	facility failed to dew care for 1 of 2 resid of substance abuse drugs. Findings include: R72's progress not R72 had a canister note indicated then canister when he for police, due to his p substance in the fa further indicated th contained the illega Review of the prog indicated R72 was pipe in his room, w facility investigating included the police confirmed for marij Review of R72's of admission diagnos abuse with intoxica abuse, major depred disorder with anxie Review of R72's ac (MDS) dated 8/18/1 diagnosis that inclu abuse along with a Review of R72's cu include the residem	v and document review, the relop a comprehensive plan of dents (R72) who had a history e and possession of illegal resident attempted to hide the ound out the staff called the ossession of an illegal ucility. The progress note e police confirmed the canister al substance of marijuana. ress notes dated 11/8/16, observed to have a marijuana hile the police were at the g a complaint. The note further tested the pipe and it was uana. diagnosis list obtained from the is sheet included; alcohol tion, psychoactive substance essive disorder, adjustment ty and personality disorder.	F 27	9 Care plan for R72 has been rev updated to include focus, goals a interventions with history of and current use of illegal substances order added to PCC for nurse to for sign of substance abuse and possession which include notifyi authorities if illegal substances a identified, which will protect othe residents. Newly discovered iss be added to the individualized pl by the appropriate department a discovered. Nurse manager to re resident's chart weekly or more for for notes regarding illicit substan and/or presence. Completion date 2-1-2017 Monitored by Nurse Managers, I MDS Nurse	and potential . Nursing observe ng local re r ues will an of care s they are eview requently ce abuse	

If continuation sheet Page 20 of 52

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		E SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED	
		245304	B. WING _		12/01/2016		
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GAP	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
F 279	Continued From pa	ige 20	F 27	'9			
	12/2/16, at 1:00 p.n did not include mor possession of illega						
F 282 SS=D	483.21(b)(3)(ii) SEI PERSONS/PER C/	RVICES BY QUALIFIED ARE PLAN	F 28	32		1/10/17	
		ive Care Plans ded or arranged by the facility, comprehensive care plan,					
	accordance with ea	qualified persons in ach resident's written plan of NT is not met as evidenced					
	review, the facility f (R42) reviewed for provided assistance	tion, interview and document ailed to ensure 1 of 3 residents activities of daily living was e with oral hygiene and lance with the care plan.		R42's care plan updated to refle resident is able to dictate person and will be encouraged to perfor own cares and when unable to re that staff assist her.	al cares m her		
	Findings include: R42's face sheet, c diagnosis of parapl	lated 12/1/16 identified a egia.		Resident R42 has been included new resident dignity grooming pr Residents have had their care pl reviewed and grooming and ADL	ogram. ans		
	R42's annual Minin 9/23/16 indicated a Status (BIMS) scor MDS also identified	num Data Set (MDS), dated Brief Interview for Mental e of 15 (cognitively intact). The I R42 required extensive taff for grooming activities.		corrections were made as neces Nursing will be inserviced by 1/10 proper care planning to address the new resident dignity groomin program. A new care planning program ha put into place that includes a stro	sary. D/17 on ADLs and g s been		
	of daily living (ADLs R42 was totally dep	sessment (CAA) for activities s), printed 12/1/16 indicated pendent upon staff in all ADLs priented. Proceed to care plan		on grooming and ADLs. A new re dignity grooming checklist has be developed. This checklist will be a daily basis to evaluate and ens	esident een used on		

Facility ID: 00758

If continuation sheet Page 21 of 52

TATEMEN	T OF DEFICIENCIES DF CORRECTION	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	<u>0938-039</u> E SURVEY IPLETED	
		045004	B. WING	<u> </u>			
		245304	D. WING _			01/2016	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CC 300 NORTH DOW STREET CANNON FALLS, MN 55009	JDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETIC DATE	
F 282	R42's care plan, da required assistance supplies and assis assistance of one s hygiene. The care get her hair washe on her request, not wash. During interview or stated she was tryi hair and did not alw on a daily basis. During observation at 10:13 a.m. nursi washed their hand uncovered R42's uc cleanse R42's skin apply powder bene uncovered R42's lo underneath the ski perineal area, rolle cleansed her perin gloves and disposi plastic bag, license proceeded to provi pressure ulcer, ren dressing materials antibacterial solutio proceeding to pack change materials. removed the soiled NA-B proceeded to a magnetic wound 42 and cover her u	age 21 level of functioning. ated 12/1/16 indicated R42 e of one staff member to set up t her for oral care, and staff in all other areas of plan also indicated R42 was to d one additional time weekly t a full bath, rather just a hair n 11/28/16, at 5:42 p.m. R42 ng to use dry shampoo on her vays even get her hair brushed of morning cares on 12/1/16, ng assistant (NA)-A and NA-B s and applied gloves, pper half and proceeded to folds and underarms and eath the folds. NA-A and NA-B sower half of her body, cleaning n folds of the abdomen and d R42 on her side and eal area. After removing their ng of the soiled linens into a ed practical nurse (LPN)-A de wound care to R42's noving the soiled wound , irrigating the wound with an on, cleansing her hands and the wound with new dressing When completed, LPN-A d dressing materials. NA-A and o roll R42 onto her side and set therapy device underneath R p with her bed linen. LPN-A	F 28	residents are receiving proper and ADL care according to c Unit managers will audit 10% weekly x 4 weeks and then r thereafter to ensure that the dignity grooming checklist is properly used. All completed will be delivered to the DON her or her designee. The DON or her designee w the QA committee monthly.	are plan. 6 of residents nonthly new resident being checklists for review by		

If continuation sheet Page 22 of 52

STATEMEN	T OF DEFICIENCIES DF CORRECTION	KANNER CALL SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	0938-039 E SURVEY PLETED	
		245304	B. WING		12/	01/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GA	RDENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 282 F 285 SS=D	room. NA-A and Na gloves and wash the without offering R4 offering to brush he During interview or stated she would he teeth after morning normal, wouldn't it? During interview or registered nurse (F expected staff to o materials to brush care supplies with A policy related to a grooming was requided a state (e) Coordination. A facility must coor pre-admission scree (PASARR) program of this part to the mavoid duplicative te includes: (1) Incorporating the PASARR level II de evaluation report in care planning, and (2) Referring all lev with newly evident disorder, intellectual	A-B proceeded to remove their neir hands, and exited the room 2 her oral care materials nor er hair or giving her the brush. n 12/1/16, at 11:13 a.m. R42 ave liked to brush her hair and cares, "That would be kind of ?" n 12/1/16, at 11:24 a.m. RN)-B stated she would have ffer R42 her grooming her hair as well as her oral	F 28			1/10/17	

If continuation sheet Page 23 of 52

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COM	PLETED
		245304	B. WING			12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON F	ALLS			00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
			1		,		
F 285		•	F 2	85			
	significant change i	n status assessment.					
		creening for individuals with a					
	mental disorder and disability.	d individuals with intellectual					
		v must not admit, on or after ny new residents with:					
	(i) of this section, ur authority has detern independent physic performed by a pers State mental health	eal and mental evaluation son or entity other than the authority, prior to admission,					
	condition of the indi	of the physical and mental ividual, the individual requires s provided by a nursing facility;					
		requires such level of he individual requires s; or					
	(k)(3)(ii) of this sect intellectual disability	pility, as defined in paragraph tion, unless the State y or developmental disability mined prior to admission-					
	condition of the indi	of the physical and mental ividual, the individual requires s provided by a nursing facility;					
	services, whether th	requires such level of he individual requires s for intellectual disability.					

If continuation sheet Page 24 of 52

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PI		APPROVED
CENTER	<u>AS FOR MEDICARE</u>	& MEDICAID SERVICES	<del></del>		O		0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245304	B. WING			12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAP	RDENS AT CANNON F	ALLS			00 NORTH DOW STREET		
	0		<u> </u>		CANNON FALLS, MN 55009	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 285	Continued From pa	ge 24	F 2	285			
	(2) Exceptions. For	purposes of this section-					
	paragraph(k)(1) of t for determinations i to a nursing facility	n screening program under this section need not provide in the case of the readmission of an individual who, after ne nursing facility, was in a hospital.					
	preadmission scree	choose not to apply the ening program under this section to the admission of an individual-					
		d to the facility directly from a /ing acute inpatient care at the					
		ursing facility services for the the individual received care in					
	before admission to	ng physician has certified, o the facility that the individual ess than 30 days of nursing					
	(3) Definition. For p	ourposes of this section-					
		considered to have a mental idual has a serious mental 483.102(b)(1).					
	intellectual disability intellectual disability	considered to have an y if the individual has an y as defined in §483.102(b)(3) a related condition as					

If continuation sheet Page 25 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE	E SURVEY PLETED
		245304	B. WING _		12/(	01/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAI	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 285	described in 435.10 (k)(4) A nursing fac mental health authority, a significant change in condition of a reside intellectual disability This REQUIREMEN by: Based on interview facility failed to ensu R81) reviewed for p had history of serior Level II preadmission review (PASRR) on Findings include: R56's face sheet, d primary diagnoses of depressive disorder An initial pre-admission Senior Linkage Line primary diagnosis of of mental illness. A social services pr indicated staff were related to the Level follow-up phone cal was charted or prov During interview on stated he routinely s health issues and h	<ul> <li>and of this chapter.</li> <li>bility must notify the state porty or state intellectual as applicable, promptly after a in the mental or physical ent who has mental illness or of for resident review.</li> <li>AT is not met as evidenced</li> <li>and document review, the ure 2 of 4 residents (R56, oreadmission screening who us mental illness (MI) had a pon screening and resident file.</li> <li>ated 11/30/16 indicated pof schizophrenia and major for schizophrenia and a history</li> <li>ogress note, dated 10/13/16 waiting on Olmsted County II PASRR screen. No Is or additional documentation</li> </ul>	F 28	85 Social Worker has notified Goodhu County that Level II screenings are required for R56 and R81, and is an completion and delivery of screenin Call placed weekly to check on prog while awaiting screenings. Level I pre-admission screening will be rev or completed as needed by Admiss prior to admission. Admissions will to Social Services if level II screenin indicated. Social Worker will notify appropriate county to complete level screening. Tracking log to be kept Social Services office, monitoring to completed by Social Worker with ea MDS Assessment (at least quarterly Completion date 1-10-2017 Monitored by MDS and Social Serv	waiting ngs. gress riewed ions report ng is the el II in o be ach y).	

If continuation sheet Page 26 of 52

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/18/2017 APPROVED 0938-0391		
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245304	B. WING			12/(	01/2016		
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
THE GA	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 285	During interview on social worker (SW) for a Level II PASR another facility in 10 called the county pu PASRR, but was ur have one on file for On 11/30/16, at 9:1 for R56 was faxed County, indicating F mental illness and o services. During interview on previous county cas did require mental I been set up in his p and would not requi services. CW-A wa PASRR assessmen R81's face sheet, d primary diagnoses schizophrenia. The (EMR) included sch listed under the dia An initial pre-admis Senior Linkage Line primary diagnosis of was checked for the (Omnibus Budget F federal program that individuals with seri Developmental Dis are requesting admit to determine the mit	<ul> <li>11/29/16, at 3:44 p.m. the</li> <li>A confirmed R56 met criteria</li> <li>R and had been admitted from 0/16. SW-A indicated she had reviously to check on the nsure of the status and did not r R56.</li> <li>0 a.m. a Level II PASRR form to SW-A from Goodhue</li> <li>R56 had documented history of did not need specialized</li> <li>11/30/16, at 9:14 a.m. R56's se worker (CW)-A stated R56 health services which had oresent county of residence tire any other specialized is not sure of the status of the nt.</li> <li>dated 12/01/2016, indicated bipolar disorder and electronic medical record hizophrenia, dated 7/19/16,</li> </ul>	F 2	85					

If continuation sheet Page 27 of 52

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (M) PROVIDERSUPPLIENCIAL DENTIFICATION NUMBER:       (D) AUUTIFILE CONSTRUCTION A BUILIDNG       (M) CONSTRUCT A BUILIDNG       (M) CONSTRUCT COMPLETED         MARE OF PROVIDER OR SUPPLIER       245304       B WING       12/01/2016         THE GARDENS AT CANNON FALLS       30 NORTH DOW STREET CANNON FALLS, MN 55009       12/01/2016         MILTIPLE TAG       IEADIMARY STREMENT OF DEFICIENCIES (EADIMARY STREMENT OF DEFICIENCIES (EADIMARY STREMENT OF DEFICIENCIES)       PH D: PROVIDER'S PLAN OF CORRECTION (EADIMARY STREMENT OF DEFICIENCIES)       PH D: PROVIDER'S PLAN OF CORRECTION (EADIMARY STREMENT OF DEFICIENCIES)       PH D: PROVIDER'S PLAN OF CORRECTION (EADIMARY STREMENT OF DEFICIENCIES)         MILTIPLE CONSTRUCTION OF LSC IDENTIFYING INFORMATION)       PH D: PROVIDER'S PLAN OF CORRECTION (EADIMARY STREMENT, WINGT EE PROCEED BY FULL (EADIC ONDERTIVE ACTION STREMENT ACTION SOULD BE (CONSTRUCTION OF LSC IDENTIFYING INFORMATION)       PH D: PROVIDER'S PLAN OF CORRECTION (EADIMARY STREMENT ACTION SOULD BE (CONSTRUCTION OF DIES) (EADIMARY STREMENT ACTION SOULD CONSTRUCTION (EADIMARY STREMENT ACTION SOULD SOULD CONSTRUCTION		-	AND HUMAN SERVICES				FORM	: 01/18/2017 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2IP CODE       THE GARDENS AT CANNON FALLS       STREET ADDRESS, CITY, STATE, 2IP CODE       CONTON FALLS       STREET ADDRESS, CITY, STATE, 2IP CODE       CONTON FALLS       STREET ADDRESS, CITY, STATE, 2IP CODE       CONTON FALLS, MN 35009       PROVIDER OF DUE       CONTON FALLS       PROVIDER OF DUE       CANNON FALLS, MN 35009       PROVIDER OF DUE       CONTONERS FUNCTION CONFERCTION       PROVIDER OF DUE       PROVIDER OF DUE       CONTINUED FOR DEFICIENCIES       PROVIDER OF DUE       CONTINUED FOR DEFICIENCIES       PROVIDER OF DUE OF CONFECTION       PROVIDER OF DUE       CONTINUED FOR DEFICIENCIES       F 285       Continued From page 27       Level II Mental Health Evaluation and final review       ON 11/29/16, at 5:07 p.m., SW-A was interviewed       REGULTION       SCREET REVIEW       ON 11/29/16, at 5:30 p.m. the administrator,       ON 121/16, at 10:57 a.m. an unsigned Level II       PASRE form, from Goodhue	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY
300 NORTH DOW STREET CANNON FALLS, MI 55009       CMUID PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOLD BE CORDERPECTIVE ACTION SHOLD BE CROCK PRECEDED TO SHOLD DEFICIENCY (EACH CORRECTIVE ACTION SHOLD BE CROCK PRECEDED TO SHOLD DEFICIENCY (EACH CORRECTIVE ACTION SHOLD BE CROCK PRECEDED TO SHOLD DEFICIENCY (EACH CORRECTIVE ACTION SHOLD BE CROCK PRECEDED THE APPROPRIATE DEFICIENCY)     CONTENT (STACK (CACH CORRECTION SHOLD BE CROCK PRECED ACTION SHOLD BE CROCK PRECED CONTENT (STACK PRECED THE ACTION SHOLD BE CROCK PRECED CONTENT AND ASSESSION SCREENING. THE RESIDENT CONTENTS (STACK PRECED THE ACTION SHOLD BE CROCK PRECED CONTENT AND ASSESSION CONTENT (STACK PRECED THE ASSESSION CONTENT (STACK PRECED THE ASSESSION CONTENT) (STACK PRECED THE ASSESSION CONTENT (STACK PRECED THE ASSESSION CONTENT) (STACK PRECED THE ASSESSION CONTENT (STACK PRECED THE ASSESSION CONTENT AND ASSESSION CONTENT (STACK PRECED ASSESSION CONTENT (STACK PRECED ASSESSION CONTENT (STACK PRECED ASS			245304	B. WING			12/	01/2016
THE GARDENS AT CANNON FALLS       CANNON FALLS, MN 55009         (M4)ID TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROJECTIVE AT DIM SHOULD BE RECULATION OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDENT Synch OR SHOULD BE (CARDSR-HEERENEED TO THE APPROPRIATE DEFICIENCY)       COMPLETON OWNER (CARDSR-HEERENEED TO THE APPROPRIATE DEFICIENCY)       COMPLETON (CARDSR-HEERENEED TO THE APPROPRIATE DEFICIENCY)       COMPLETON (CARDSR-HEERENEED)       COMPLETON (CARDSR-HEERENEED)       COMPLETON (CARDSR-HEERENEED)       COMPLETON (CARDSR-HEERENEED)       COMPLETON (CARDSR-HEERENEED)       COMPLETON (CARDSR-HEERENEED)       COMPLETON (CARDSR-HEERENEED)       COMPLETON (CARDSR-HEERENEED)       COMPLETON (CARDSR-HEERENEED)       CARDSR-HEERENEED (CARDSR-HEERENEED APPROPRIATE)       CARDSR-HEERENEED (CARDSR-HEERENEED APPROPRIATE)       CARDSR-HEERENEED (CARDSR-HEERENEED APPROPRIATE)       CARDSR-HEERENEED (CARDSR-HEERENEED APPROPRIAE	NAME OF F	PROVIDER OR SUPPLIER						
PIEER TAG       IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       IEACH CONSERPECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE       Convincing DEFICIENCY)         F 285       Continued From page 27 Level II Mental Health Evaluation and final review of the need for specialized services is required."       F 285       F 285         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 and Resident Review (PASRR) and confirmed there was not one on file.       F 285         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.       F 309       12/27/16         On 11/29/16, 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.       F 309       12/27/16         F 308       Sa2.4, 483.25(k)(I) PROVIDE CARE/SERVICES SS=G       F 309       12/27/16         F 304       483.24, Quality of life Quality of life Auguity of life as 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       F 309 <td>THE GAP</td> <td>RDENS AT CANNON F</td> <td>FALLS</td> <td></td> <td></td> <td></td> <td></td> <td></td>	THE GAP	RDENS AT CANNON F	FALLS					
Level II Mental Health Evaluation and final review of the need for specialized services is required." 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. On 11/29/16, at 5:30 p.m. the administrator, director of nursing and admission coordinator were together in the administrator Scifice. When interviewed , they stated they were not aware of R81 lacked a Level II PASRR. 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. A policy related to PASRR assessments was requested, none was provided. F 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES SS=G FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life Quality of life Auguity of life Quality of life Auguity of life Quality of life Auguity	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
comprehensive assessment and plan of care.	F 309	Level II Mental Hea of the need for spec On 11/29/16, at 5:0 regarding the lack of Screening and Res screening. The Sen was reviewed with t the need for the Lev and confirmed there On 11/29/16, at 5:3 director of nursing a were together in the interviewed , they s R81 lacked a Level On 12/1/16, at 10:5 PASRR form, from faxed to the SW-A. documented history need specialized set A policy related to F requested, none wa 483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of lif Quality of life is a fu applies to all care a residents. Each res facility must provide services to attain or practicable physical well-being, consister	<ul> <li>alth Evaluation and final review cialized services is required."</li> <li>7 p.m., SW-A was interviewed of a Level II Pre-Admission ident Review (PASRR) nior Linkage Line document the SW-A. The SW-A stated vel II screening was missed e was not one on file.</li> <li>0 p.m. the administrator, and admission coordinator e administrator's office. When tated they were not aware of II PASRR.</li> <li>67 a.m. an unsigned Level II Goodhue County, for R81 was The form indicated R81 had y of mental illness and did not ervices.</li> <li>PASRR assessments was as provided.</li> <li>) PROVIDE CARE/SERVICES ELL BEING</li> <li>ie undamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest I, mental, and psychosocial ent with the resident's</li> </ul>					12/27/16

Facility ID: 00758

If continuation sheet Page 28 of 52

		& MEDICAID SERVICES				0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY PLETED		
		245304	B. WING _		12/	01/2016		
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE				
THE GAI	RDENS AT CANNON I	FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETIOI DATE		
F 309	provided to resident consistent with prof the comprehensive and the residents' ( (I) Dialysis. The face residents who requi- services, consistent of practice, the com- care plan, and the op- preferences. This REQUIREMED by: Based on interview facility failed to ens- control chronic mod available timely for for pain control. R4 when the facility war medication supply for pharmacy provided time R42 experience Findings include: R42's face sheet da diagnoses of parap- pain syndrome. R42's annual Minin 9/23/16, indicated a Status (BIMS) scor- intact. The MDS also needed pain medic	ent. Insure that pain management is the who require such services, fessional standards of practice, person-centered care plan, goals and preferences. cility must ensure that ire dialysis receive such t with professional standards hprehensive person-centered residents' goals and NT is not met as evidenced w and document review, the ure narcotic pain medication to derate to severe pain was 1 of 1 resident (R42) reviewed 2 experienced actual harm as out of the narcotic for three days before the 1 the medication, during which	F 30	Resident #42 was seen by a phy pain and a new program was put place to ensure that pain medicat always available. Under the direction of the DON, r conducted a review of all residen pain medication to ensure approp availability and delivery of pain medications is taking place. Corrivere made as required. Nurses will be in-serviced on 1-4- ordering medications including na and e-kit use to ensure that medi including narcotics are properly o so they are always available for re- with orders for them. This training include steps to be taken for varia medication scenarios, including r refusing pain medications on han increased narcotic usage and pre- a rapid depletion of any back-up to The evening nurse manager will a	into tions are nursing ts on oriate ections -17 on arcotics cations, rdered esidents g will ous pain esident d, eventing narcotic.			

Facility ID: 00758

	IMENT OF HEALTH		FORM	01/18/2017 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245304	B. WING			12/0	01/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAI	RDENS AT CANNON F	ALLS			00 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	R42's Care Area As indicated R42 had a that limited her day indicated R42 was request pain medic R42's care plan las R42 was at risk for of having discomfor included administer for pain. R42's physician's o orders for oxycodor analgesic) 5 milligra every four hours as related to chronic p orders also identifie patch 25 microgram well as gabapentin nerve pain) 400 mg chronic pain syndro R42's pain interview indicated R42 expe which was moderat assessment indicate four out of ten (10 b and indicated R42 i R42's medication a dated 11/16 indicate oxycodone 5 mg tai the month of Nover ranging from a ten The November 201 received any oxyco	A sessment (CAA) for pain almost constant moderate pain to-day activity. The CAA alert, oriented and able to ations. t revised 7/10/16, indicated impaired comfort with a goal t less than daily. Interventions ing medications as ordered rders dated 12/1/16, identified he (a short acting narcotic am (mg) tablets by mouth needed (PRN) for pain ain syndrome. The physician's ad Fentanyl (a narcotic) pain his every 72 hours topically, as (a medication used to treat by mouth three times daily for ime. A assessment dated 9/23/16, rienced pain almost constantly e in intensity. The pain ed R42 rated the pain as a being the most severe pain), ndicated a 4 was tolerable. dministration record (MAR) ed R42 had received blets a total of 14 times during nber 2016 for pain levels to a five on a ten-point scale. 6 MAR indicated R42 had not done from 11/14/16 to tation on the MAR indicated	F 3	09	and Thursdays to ensure that an adequate supply of narcotics is on and that all re-orders have current on file at the pharmacy. Unit manage and the DON will be advised when narcotic supply is low. The Director of Nursing or her desi will audit back-up narcotic supplies sufficiency weekly x 4 and then mo thereafter. The DON or designee were port monthly to the QA Committer	scripts gers the gnee for nthly <i>i</i> ll	

Facility ID: 00758

If continuation sheet Page 30 of 52

		AND HUMAN SERVICES			FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245304	B. WING		12/(	01/2016
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GAR	RDENS AT CANNON F	FALLS		00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	Continued From pa	-	F 309			
	and 17, 2016. R42 acetaminophen dos 11/15/16, was ident R42 had received a					
	11/16/16, at 4:30 a. level 5 and received acetaminophen. At	pain ranked at a 7. On m. R42 rated her pain at a d an additional 1000 mg of 5:43 a.m. on 11/17/16, R42 rt at a ten. A nursing progress				
	note dated 11/17/16 had been calling ou nerves." The note thad orders for oxyc medication had run from the pharmacy.	6 at 5:45 a.m., indicated R42 ut and crying "Burning from further indicated the resident codone however, the out and had been reordered . The progress note indicated ued to cry out and had been				
	given PRN Tylenol	1000 mg at 5:45 a.m.				
	required as needed follow up notes on t recored (MAR) india	experienced discomfort and d acetaminophen, documented the medication administration cated "E" (for effective) after minophen R42 had received.				
	October and Noven oxycodone supply h 11/13/16, and a new in until four days lat	sheets for the months of mber 2016 identified R49's prn had run out at 1:45 p.m. on w supply card was not checked ter on 11/17/16, with the first from the card at 8:08 p.m. on				
	stated she had exp days when she did stated she thought due to the doctor ne	11/28/16, at 6:13 p.m. R42 erienced severe pain for three not have her oxycodone. R42 they were out of the narcotic eeded to send a new script to ne medication and then R42				

If continuation sheet Page 31 of 52

	-	I AND HUMAN SERVICES E & MEDICAID SERVICES				F	ORM /	01/18/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		E CONSTRUCTION		3) DATE	E SURVEY PLETED
		245304	B. WING				12/0	01/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
THE GAI	RDENS AT CANNON F	FALLS			00 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
F 309	remembered this w 2016. R42 stated n oxycodone from the supply. When aske had gotten, R42 sta a nine!" The nine w scale and 9 bing ex oxycodone helped i experienced in her During a follow-up i p.m. R42 clarified h (worse than excruc when she had not r (between 11/13 and The director of nurs 11/30/16 at 4:32 p.r R42 had run out of 11/13/16, and confi expected staff to ca to provide coverage supply. The DON s the facility's policy r supplies of medicat stated registered nu person to ask abou During interview wit (LPN)-B on 12/1/16 the procedure to get the pharmacy inclue getting authorizatio the emergency kit. staff had difficulty p narcotics from the p	vas taken care of in November to one had offered her e facility's emergency narcotic ed how severe her pain level ated "Oh, my [expletive] it was vas based on a 1 to 10 pain corutiating. R42 said the manage the nerve pain she hands. interview on 11/30/16, at 3:51 her pain had been an 11 tiating) during the time period received the oxycodone d 11/17/16). sing (DON) was interviewed on m., she stated she was aware her oxycodone around irmed she would have all the doctor on call to be able e from their emergency kit tated she was unsure about related to procuring emergency tion from the pharmacy. She urse (RN)-B would be the best at this situation. th licensed practical nurse of at 8:05 a.m., LPN-B stated et emergency narcotics from ded calling the pharmacy and n to take a medication from LPN-B indicated sometimes procuring re-order supply of pharmacy when the pharmacy	F 3	809				

If continuation sheet Page 32 of 52

		AND HUMAN SERVICES			FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245304	B. WING		12/	01/2016
NAME OF	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GA	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	stated she recalled on 11/13/16. LPN-/ medication label to days before it ran o faxed the pharmacy came in due to the script for the medic not realize for a wh a new prescription. R42's physician for during the time R42 oxycodone, LPN-A and the acetaminop expressed was effer During interview on confirmed R42 had several days betwe RN-B said the med the pharmacy but n sometimes had trou the prescriptions ra During interview on consultant pharmacy facility should have physician to get an oxycodone when R available in their e-I A facility policy, unti "the pharmacy shal product needed on promptly as is reasi event pharmacy ca product ordered on reasonably prompt its best efforts to de	R42 running out of oxycodone A stated she had pulled the re-order the medication a few put. LPN-A also stated she had y for more supply which never pharmacy requiring a renewed ation. LPN-A stated staff did ile that the pharmacy required She said they had then faxed the new prescription and 2 was waiting for her recalled offering gabapentin ohen which she said R42 had active. 12/1/16 at 10:09 a.m., RN-B run out of oxycodone for then 11/13/16 and 11/17/16. lication renewal was faxed to never came, and that staff uble getting medication when in out. 12/1/16 at 12:51 p.m., the cist (CP) stated staff at the called the pharmacy or on-call emergency supply of 42 was having pain, as it was	F 309			

If continuation sheet Page 33 of 52

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	OMB NO	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		IPLETED	
		245304	B. WING _		12/	01/2016	
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GAR	RDENS AT CANNON F	FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 309	Continued From pa	ge 33	F 30	99			
	pharmacy product t pharmacy."	o facility more promptly than					
F 312 SS=D	483.24(a)(2) ADL C DEPENDENT RES	ARE PROVIDED FOR	F 31	2		1/10/17	
	activities of daily liv services to maintain personal and oral h	no is unable to carry out ing receives the necessary n good nutrition, grooming, and ygiene. NT is not met as evidenced					
	Based on observative review, the facility factoriand grooming needs provided for 1 of 3	tion, interview and document ailed to ensure oral hygiene Is (hair combed) were residents (R42) reviewed who on staff assistance with ing (ADL).		Resident #42 has a new ADL place which includes oral care grooming; this is being provide A new policy on oral care and A grooming has been developed have been reviewed to ensure are receiving appropriate ADL	and d daily. ADL Residents that they		
	Findings include:			grooming, and oral care. Nursing staff – nurses and NAI			
	diagnosis of paraple Data Set (MDS), da Interview for Menta (cognitively intact).	ated 12/1/16 identified a egia. R42's annual Minimum ated 9/23/16 indicated a Brief I Status (BIMS) score of 15 The MDS also identified R42 assistance of two staff for		re-trained on the elements of p care for residents, ADL care, a grooming. Return demonstratio required to ensure adequate co with training. A new resident dignity program developed which involves revie resident care daily to ensure th	roper oral nd ons will be ompliance has been owing		
	of daily living (ADLs R42 was totally dep	sessment (CAA) for activities b) printed 12/1/16, indicated bendent upon staff for all ADL's ted. Proceed to care plan to vel of functioning.		grooming has been done proper combed, fingernails cleaned, p bathing, and oral care. A form a checklist will be used to evalu- residents daily. Unit managers or their designed	erly, hair roper created as uate		
	required assistance supplies and assist	ed 12/1/16, indicated R42 of one staff member to set up her for oral care and taff in all other areas of		audit weekly x 4 and then mon thereafter to ensure that the re dignity review is being done da include on the spot observatior	thly sident ily; this will		

Event ID:2C8411

Facility ID: 00758

If continuation sheet Page 34 of 52

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245304	B. WING		12/	01/2016
AME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HE GA	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 312	hygiene. During interview on stated she was tryin hair and did not alw on a daily basis. During observation at 10:13 a.m. nursin washed their hands uncovered R42's up cleanse R42's skin powder beneath the uncovered R42's lo underneath the skin perineal area, rolled cleansed her perine gloves and disposin plastic bag, license proceeded to provid pressure ulcer, rem dressing materials, antibacterial solutio proceeding to pack change materials. N a.m. cares after LP NA-A and NA-B pro side and placed a r device beneath R42 bed linen. LPN-A tu and exited the room to remove their glov exited the room wit materials nor offerin her the brush to con	of morning cares on 12/1/16, of morning cares on 12/1/16, ng assistant (NA)-A and NA-B s and applied gloves, pper body and proceeded to folds and underarms, applying e folds. NA-A and NA-B	F 312	residents on random days of the and a thorough review of the Res Dignity Checklist to ensure that a are being managed properly. After reviewing, the Unit Managers will the checklists to the DON. The Director of Nursing will report to the QA Committee on this pros	sident II items er deliver t monthly	

If continuation sheet Page 35 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391				
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED	
		245304	B. WING _		12/(	01/2016	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
THE GAR	IDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 312 F 318 SS=D	registered nurse (R expected staff to off materials to brush h care supplies with n A policy related to a grooming was reque 483.25(c)(2)(3) INC DECREASE IN RAN (c) Mobility. (2) A resident with li receives appropriate increase range of m decrease in range of (3) A resident with li appropriate services to maintain or impro- practicable indepen mobility is demonstr This REQUIREMEN by: Based on observat review the facility fa (ROM) exercises we recommended by th	<ul> <li>12/1/16, at 11:24 a.m.</li> <li>N)-B stated she would have fer R42 her grooming her hair as well as her oral norning cares.</li> <li>ctivities of daily living and ested, none was provided.</li> <li>REASE/PREVENT NGE OF MOTION</li> <li>Imited range of motion e treatment and services to notion and/or to prevent further of motion.</li> <li>Imited mobility receives s, equipment, and assistance by emobility with the maximum dence unless a reduction in rably unavoidable.</li> <li>NT is not met as evidenced ion, interview and document iled to ensure range of motion</li> </ul>	F 31	2         8         8         8         8         9         8         9         9         10         11         12         13         14         15         15         16         16         17         16         16         17         16         17         16         17         16         17         16         17         16         17         16         17         17         17         16         17         16         17         16         17         17         17         18         17         17         17         17         17         17         17         18         17         17	place ian. herapy I their stalled eir s that	1/10/17	
		ated 12/1/16 identified a egia. R42's annual Minimum		explained below, designed to correc deficiency. Nursing and therapy staff have been			

Facility ID: 00758

If continuation sheet Page 36 of 52

		& MEDICAID SERVICES			DMB NO. 0938-039	
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245304	B. WING _		12/	01/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GA	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 318	Data Set (MDS) ass indicated a Brief Int (BIMS) score of 15 also identified R42 f assistance with acti impairments in range extremities. R42's care area ass printed 12/1/16, ind dependent upon sta able to be out of be pressure ulcer. The to no voluntary move extremities, was ext all ADLs and was all care plan to maintal R42's care plan dat limited range of mo- to paraplegia and m- identified R42 had r in place but exhibited daily refusals. No pre extremity range of r R42's functional mar recommendations, to perform passive bilateral foot, ankle, internal/external rot abduction/adduction Program in binder r calendar when com (Sunday, Tuesday, R42's nursing progr 11/2016 reflected of	Sessment dated 9/23/16, erview for Mental Status (cognitively intact). The MDS required extensive to total vities of daily living and had ge of motion to both lower sessment (CAA) for ROM icated R42 was totally aff for transfers and was only d one hour daily due to a cCAA identified R42 had little rement in the bilateral lower tensively dependent on staff in lert and oriented. Proceed to in current level of functioning. ed 12/1/16, indicated R42 had tion to the left hand secondary on-use. The care plan multiple restorative programs ed non-compliance and nearly rogram was listed for lower notion on the care plan. aintenance program dated 8/19/16 indicated staff range of motion (PROM) knees and hip ation and hip n x 10 [repetitions] each. hanging on closet, initial pleted. To be done 3 x/week	F 31	trained on a new method to ensuresidents receive their therapy as by the physician. A calendar has created and designated solely for therapy. Each unit has a copy, emanager, the therapy departmer Director of Nursing. Each week, meeting, the IDT will review the calendar to ensure that resident are listed there. Each shift, physis therapy and nursing check the cand mark off once therapy is conditioned therapy is completed. The DON or her designee will date and the resident therapy cale ensure compliance. The head of will also do his/her own weekly a ensure follow-through on the parstaff. The DON and head of therapy we monthly to the QA Committee or program.	s ordered been r resident ach unit it, and the at the IDT herapy therapies cal alendar npleted. ensure a weekly ndar to therapy udit to t of her	

If continuation sheet Page 37 of 52

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE	E SURVEY PLETED
		245304	B. WING	ì		12/	01/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE GA	RDENS AT CANNON F	FALLS			800 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 318	<ul> <li>p.m. The entry indiunable to be perform [R42's] leg.</li> <li>During interview on stated she was not to her lower extrem program instruction taped to the front of for staff to initial the No initials were sign R42 stated the last exercises was in 8/</li> <li>During interview on activities director (A the restorative aide eliminated and now The position had now The position had now the position had now for the restorative aide eliminated and now the position had now the positin the position had now the positin the positi</li></ul>	icated the exercises were med due to unable to lift 11/18/16, at 5:43 p.m. R42 receiving her range of motion nities. A functional maintenance a sheet, dated 8/19/16 was f her closet next to a calendar e ROM exercises labeled 9/16. ned off on the calendar and time she had received the /2016. 11/30/16, at 11:31 a.m. the AD) stated that she used to be e, however that position was v she was assigned activities. ot been replaced to her e was unsure who was doing d the restorative/functional am participation was usually		318			

If continuation sheet Page 38 of 52

		AND HUMAN SERVICES			FORM	01/18/2017 APPROVED 0938-0391			
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		(X3) DATE	E SURVEY IPLETED			
		245304	B. WING		12/	01/2016			
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE					
THE GA	RDENS AT CANNON F	FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE			
F 318	trouble keeping her wheelchair, and sin the functional main very important to pr the lower extremitie and performed an a ROM at this time, li ROM. The PT state five degrees of dors had increased tone but had no new cor When interviewed of registered nurse (R extremity ROM was was "Too heavy," at the program. During interview on director of nursing ( why R42's restorati extremities was not RN-B would be the the lack of implement Restorative program requested for R42 f provided. The facility policy en Exercises, undated the exercises were individual who perfor range of motion exe exercise was passin exercise and how th procedure, problem	r legs on her footrests in the ice R42 was not able to get up, tenance programming was revent further contractures of es. The PT went to R42's room assessment of R42's lower fting R42's legs to perform ed R42 had lost approximately siflexion in both of her feet and and was "tight" in both legs, ntractures. on 12/1/16, at 11:24 a.m. the RN)-B stated R42's lower is not performed because R42 nd also due to R42 refusing a 2/1/16, at 11:23 a.m. the (DON) stated she was not sure ve program for her lower t being implemented and that best person to question about entation. m documentation was from Point of Care, none was ntitled Range of Motion l indicated the date and time performed, name of the ormed the procedure, type of ercise given, whether the ve or active, length of the he resident participated in the ns or complaints made by the ent refusals should be	F 318						

If continuation sheet Page 39 of 52

		AND HUMAN SERVICES				FORM	APPROVED
	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION		0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245304	B. WING			12/(	01/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,                                     </u>	
THE GAI	RDENS AT CANNON F	ALLS					
					CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334 SS=E	483.80(d)(1)(2) INF PNEUMOCOCCAL		F 3	34			1/10/17
	(d) Influenza and pr	neumococcal immunizations					
	(1) Influenza. The fa and procedures to e	acility must develop policies ensure that-					
	each resident or the receives education	ne influenza immunization, e resident's representative regarding the benefits and s of the immunization;					
	immunization Octob annually, unless the	offered an influenza per 1 through March 31 e immunization is medically he resident has already been his time period;					
		the resident's representative to refuse immunization; and					
		nedical record includes indicates, at a minimum, the					
		nt or resident's representative ation regarding the benefits ffects of influenza					
	immunization or did	nt either received the influenza I not receive the influenza o medical contraindications or					
		disease. The facility must d procedures to ensure that-					
	(i) Before offering th	ne pneumococcal					

If continuation sheet Page 40 of 52

	MENT OF HEALTH							FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/S		(X2) MUL A. BUILD		E CONSTRUCTION	_	(X3) DATE	E SURVEY PLETED
		24	5304	B. WING				12/0	01/2016
NAME OF F	PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
THE GAF	RDENS AT CANNON	FALLS			-	00 NORTH DOW STREET			
(X4) ID PREFIX TAG		ATEMENT OF DEFIC Y MUST BE PRECE .SC IDENTIFYING IN	DED BY FULL	ID PREFI TAG	x	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPP ICIENCY)	BE	(X5) COMPLETION DATE
F 334	Continued From pa immunization, each representative rece benefits and potent immunization; (ii) Each resident is immunization, unle	n resident or the eives education tial side effects s offered a pneu ss the immuniz	of the of the umococcal ration is	F 3	34				
	<ul> <li>medically contraindicated or the resident has already been immunized;</li> <li>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</li> <li>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</li> </ul>								
	(A) That the reside was provided educ and potential side e immunization; and	ation regarding	the benefits						
	(B) That the reside pneumococcal imm the pneumococcal contraindication or This REQUIREME by:	nunization or di immunization c refusal.	d not receive due to medical						
	Based on interview facility failed to imp Control and Prever to pneumococcal c 7 of 9 residents (F R60) whose vaccin Findings include:	plement the Cention (CDC) gui conjugate vacci R12, R1, R63, f nation histories	nter for Disease delines related ne (PCV13) for R24, R39, R29, were reviewed.			Nursing Dept. will, determine whether received either of th vaccines, and retrie administration if ab recorded in the resi historical, and will s vaccine received w If either vaccine can	residents have ne pneumococca eve dates of le. Vaccinations idents record as state whether the as PCV 23 or P nnot be docume	al s will be e CV13. ented,	
FORM CMS-25	Center for Disease identified, "Adults 6 67(02-99) Previous Versions	65 years of age			Fa	one or both vaccine be offered and doct	umented in the		Page 41 of 52

		AND HUMAN SERVICES	T		FORM OMB NO.	APPROVE 0938-039		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED		
		245304	B. WING _		12/0	01/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE			
THE GA	RDENS AT CANNON	FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 334	have not previously have previously rec PPSV23 [pneumod 23] should receive PCV13 should be g receipt of the most R12's immunization indicated the 71 ye pneumococcal vac it did not indicate w current immunization indicated the 69 ye pneumococcal vac it did not indicate su pneumococcal vac recommended by 0 R1's immunization indicated the 69 ye pneumococcal vac it did not indicate su pneumococcal vac it did not indicate su pneumococcal vac it did not indicate su pneumococcal vac recommended by 0 R63's immunization indicated the 74 ye pneumococcal vac did not indicate whi current immunization indicate subsequer vaccine was offered CDC guidelines. R24's immunization indicated the 73 ye pneumococcal vac did not indicate whi	v received PCV13 and who peived one or more doses of poccal polysaccharide vaccine a dose of PCV13. The dose of given at least 1 year after recent PPSV23 dose." In record dated 12/1/16, ar old had received a cination on 3/7/2007, however, which vaccine was given. The on record provided on 12/1/16, albsequent dosing of the cine was offered to R12 as CDC guidelines. record, dated 12/1/16, ar old had received a cination on 7/1/2007, however, which vaccine was given. The on record provided on 12/1/16, ar old had received a cination on 7/1/2007, however, which vaccine was given. The on record provided on 12/1/16, albsequent dosing of cine was offered to R1 as	F 3:	<ul> <li>residents records. Residents R12,R24, R39 and R60 will b PCV 23 by 1/10/2017 if not contraindicated, and offered 2/10/2018. Licensed nurses educated at the Nursing Mee 1/4/2017 regarding recording vaccine to record and that bo must be offered and docume Coordinator will monitor vaco with each MDS Assessment least quarterly) and will upda Nurse Manager when vaccin missing from a resident's immi- record.</li> <li>Completion date 1-10-2017 Monitored by MDS, Nurse M</li> </ul>	pe offered PCV 13 by will be ting on which oth vaccines onted. MDS conted. MDS completed (at te DON and ations are munization			

If continuation sheet Page 42 of 52

		AND HUMAN SERVICES				FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245304	B. WING			12/	01/2016
NAME OF !	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GA	RDENS AT CANNON F	FALLS			00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 334	to indicate subseque vaccine was offered guidelines. R39's immunization indicated the 99 yea pneumococcal vaca did not indicate whi The current immun to indicate subseque vaccine was offered guidelines. R29's immunization indicated the 75 yea pneumococcal vaca it did not indicate w The current immun to indicate subseque vaccine was offered guidelines. R60's immunization indicated the 71 yea pneumococcal vaca did not indicate whi The current immun to indicate subseque vaccine was offered guidelines. R60's immunization indicated the 71 yea pneumococcal vaca did not indicate whi The current immun to indicate subseque vaccine was offered guidelines. When interviewed of director of nursing of aware of the current the pneumococcal for confirmed resident" the a second pneum	an record, dated 12/1/16, ar old had received a cination on 7/2/15, however it ich vaccine was given. ization record provided failed uent dosing of pneumococcal d as recommended by CDC in record, dated 12/1/16, ar old had received a cination on 10/25/10, however thich vaccine was given. ization record provided failed uent dosing of pneumococcal d as recommended by CDC in record, dated 12/1/16, ar old had received a cination on 9/26/15, however thich vaccine was given. ization record provided failed uent dosing of pneumococcal d as recommended by CDC in record, dated 12/1/16, ar old had received a cination on 9/26/15, however it ich vaccine was given. ization record provided failed uent dosing of pneumococcal d as recommended by CDC	F 3	34			

Facility ID: 00758

If continuation sheet Page 43 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON F	ALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 334	Continued From pa	-	F 33	4		
F 412 SS=D	Vaccine for the Sup Minnesota Region v undated and unsign be offered pneumoor preventing pneumoor the policy indicated pneumococcal vaccom made in accordance Disease Control and recommendations a Number 8 of the po concerning our facil pneumococcal vacco the Infection Preven Services." 483.55(b)(1)(2)(5) F DENTAL SERVICE (b) Nursing Facilitie The facility- (b)(1) Must provide resource, in accord part, the following d needs of each reside (i) Routine dental se under the State plan (ii) Emergency dent	s or obtain from an outside ance with §483.70(g) of this lental services to meet the dent: ervices (to the extent covered n); and tal services; ssary or if requested, assist	F 41	2		1/10/17

If continuation sheet Page 44 of 52

		AND HUMAN SERVICES			FORM	01/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		12/	01/2016
NAME OF I	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
THE GAR	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 412	Continued From pa	ge 44	F 41	2		
	(ii) By arranging for dental services loca	transportation to and from the ations;				
	wish to participate t dental services as a under the State pla This REQUIREMEN by: Based on observat review the facility fa for 1 of 3 residents routine dental servi Findings include:	NT is not met as evidenced tion, interview and document ailed to provide dental services (R72) reviewed who required		DSM will address oral status, M coordinator will double check DS assessment for completion or or in Dietary Assessment with each Assessment (at least quarterly). be seen by In-House dentist on Ongoing dental care schedule is maintained by In-House Service	SM ral status MDS R72 to 1/3/2017.	
	11/29/16, at 2:30 p. several darkened c throughout his mout teeth that included decayed teeth due abuse of methampl it was hard to chew chew regular textur texture. R72 stated swallowing. R72 fur seen by a dentist for to have his teeth ex- times. Review of R72's ad (MDS) assessment resident as having cavity and did not ir or decayed teeth. F quarterly MDS asses	m. R72 was noted to have hipped and missing teeth th. R72 indicated he had bad missing, chipped and to his long time substance hetamine. R72 further included by but indicated he would rather red food than to adjust the he did not have problems with or many years and would like camined, because they hurt at mission Minimum Data Set to dated 8/18/16, identified the no problems with his oral nclude R72's chipped, missing Review of the most recent essment dated 11/4/16, had no mouth pain, swallowing		agreement. R72's care plan has updated. All residents will be seen by in-h dental after signing the in-house agreement, or will be encourage an outside dentist if they choose utilize in-house services as evid signed consent forms in residen Social worker will document dec in-house services, and will moni appointments and will update In Services monthly with new resid have chosen to use In-House D Services. Completion date 1-10-2017 Monitored by MDS Coordinator Services	been ouse service d to see not to enced by t records. line of tor dental House ents who ental	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245304	B. WING			12/	01/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON F	ALLS			800 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 412	at 185 pounds and set-up assistance. Review of the mos for R72 dated 11/1/ a regular diet and e Weight is stable at with swallowing. Th the condition of the Review of R72 's o 11/1/16, identified th having no problems refused to allow sta Review of R72's cu resident as being in set- up and receive eats independently obtain, record and n R72 eats 50 percer further indicated R7 brushes them indep not include nor add or decayed teeth. Interview with the fa 11/29/16, at 2:00 p. schedules needed residents, indicated and desire for denta him seen by the on dentist conducted e 10/19/16. The socia	R72's weight has been stable brushes his own teeth after t current dietary assessment 16, indicated the resident is on ats 50 percent of his meals. 185 pounds . No problems e assessment did not include residents teeth. ral data collection tool dated he residents oral cavity as s other than missing teeth, but ff to complete the exam. rrent plan of care identifies the idependent with eating after s a regular diet. Interventions: after set up assistance and monitor weights and fluids. It of his meals. The care plan 22 has natural teeth and bendently. The care plan did ress R72's chipped, missing acility social service director on m. who monitors and dental exams for the she was aware of R72's need al services but failed to have site dentist. The on-site exams at the facility on al service director indicated a	F 4	112			
F 441	checked into as of t	had not been set up nor this time for R72. a)(f) INFECTION CONTROL,	F4	41			12/27/16

If continuation sheet Page 46 of 52

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245304	B. WING			12/	01/2016
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAR	GARDENS AT CANNON FALLS				00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 SS=F	Continued From pa PREVENT SPREAL (a) Infection preven The facility must es and control program a minimum, the follo (1) A system for pre- investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin accepted national s implementation is F (2) Written standard for the program, wh limited to: (i) A system of surv possible communic before they can spr facility; (ii) When and to wh communicable dise reported; (iii) Standard and tra to be followed to pro- (iv) When and how resident; including to	ge 46 D, LINENS tion and control program. tablish an infection prevention n (IPCP) that must include, at owing elements: eventing, identifying, reporting, ontrolling infections and ases for all residents, staff, and other individuals under a contractual upon the facility assessment og to §483.70(e) and following tandards (facility assessment Phase 2); ds, policies, and procedures inch must include, but are not eillance designed to identify able diseases or infections ead to other persons in the nom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to:	F 4	41			
	(A) The type and du	uration of the isolation,					

		AND HUMAN SERVICES				FORM /	01/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245304	B. WING	ì		12/0	01/2016
NAME OF F	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALLS			300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	<ul> <li>involved, and</li> <li>(B) A requirement to least restrictive possion circumstances.</li> <li>(v) The circumstance must prohibit emploid disease or infected contact with resider contact will transmit (vi) The hand hygie by staff involved in</li> <li>(4) A system for requirement the facility's factions taken by the facility's factions taken by the facility's factions. Person process, and transport of infection.</li> <li>(f) Annual review.</li> <li>(f) Annual review.</li> <li>(f) Annual review of its program, as necess.</li> <li>This REQUIREMED by:</li> <li>Based on interview facility failed to impinfection control process and infecting illnesses and infecting read to others.</li> </ul>	e infectious agent or organism hat the isolation should be the ssible for the resident under the ces under which the facility byees with a communicable skin lesions from direct nts or their food, if direct t the disease; and ene procedures to be followed direct resident contact. cording incidents identified IPCP and the corrective e facility. nel must handle, store, port linens so as to prevent the The facility will conduct an a IPCP and update their	F 4	441	The Director of Nursing and Infecti Control Nurse will implement a trac log on each unit to track antimicrob administration, lab cultures and dis to improve the infection control corr by 1/1/2017. Nursing will obtain res cultures which have been sent to la	king ial eases relation sults of	
	Findings include:	dod by registered surger (DN). A			analysis and report results on the tr log beginning 1/1/2017. A monthly tracking log will be maintained in th	e office	
	A binder was provid	ded by registered nurse (RN)-A			of the infection control nurse begin	iing	

Facility ID: 00758

If continuation sheet Page 48 of 52

TATEN #EN "					OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245304	B. WING _		12/	01/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	IP CODE	
THE GAI	RDENS AT CANNON F	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009	I.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 441	<ul> <li>441 Continued From page 48 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:</li> <li>February 2016:</li> <li>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.</li> <li>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.</li> <li>There was no further provided information.</li> <li>March 2016:</li> </ul>		F 44	41 the month of January, 2 will be monitored throug monthly tracking log. Th manger will review the u completion, copy and giv control nurse beginning nurses will be educated review policy at the nurs 1/4/2017 Completion date 12-28-3 Monitored by Director of Infection Control Nurses	h the use of the ne evening Nurse nit logs weekly for ve to the infection 1/1/2017. Staff on procedure and ing meeting on 2016 Nursing and	
	received antibiotics the month for differ- urinary tract infection yeast. The report la organism cultures of determined to be con acquired. Seven of the fourter resident was treated twice daily from 3/8	ort identified 14 residents had or other medication during ent diagnoses which included on (UTI), skin, bronchitis and icked room numbers, or if the infection was ommunity or in-house en residents had UTI. A d with Cipro 250 mg by mouth -3/14/16. The urine culture or an organism identified.				

If continuation sheet Page 49 of 52

		AND HUMAN SERVICES				FORM	MAPPROVED
		& MEDICAID SERVICES				<u>OMB NO. 0938-0391</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY
		245304	B. WING	i		12	2/01/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAR	RDENS AT CANNON F	ALLS			300 NORTH DOW STREET		
		A220			CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 441	Continued From par Another resident war mg daily for 7 days identified type of inf documented on the "? infection" listed w documented on the treated with Levaque days. The collected data I the infections in the cause of each infect or were spreading in There was no further April 2016: An order listing repor- where residents had the month. Two of the documented, the ot lacked any room nu documentation of our resolution or if the in community or in-hou The collected data I the infections in the cause of each infect or were spreading in There was no further May 2016: An order listing report	ge 49 as treated with Levaquin 500 for prophylaxis without an ection or culture results report. Another resident had with not culture results report. This resident was in 500 mg by mouth daily for 5 lacked trending or analysis of facility to determine the stion or if they had potential to n the facility. er provided information. ort identified 12 infections d received antibiotics during he 12 had sites of infection thers were blank. The report umbers, type of infection, any rganism, consistent date of nfection was determined to be use acquired. lacked trending or analysis of facility to determine the stion or if they had potential to	F 2	-	DEFICIENCY)		
	where residents had						

Facility ID: 00758

If continuation sheet Page 50 of 52

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	0MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COM	PLETED
		245304	B. WING			12/	01/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GA	RDENS AT CANNON F	ALLS			CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	lacked any room nu documentation of o resolution or if the in community or in-ho The collected data if the infections in the cause of each infect or were spreading i There was no furthe June 2016: An order listing report where residents have were documented st detail related to the Nystatin. The report resolution or if the in community or in-ho The collected data if the infections in the cause of each infect or were spreading i There was no furthe July 2016: An order listing report where residents have were no documented lacked room numb documentation of o	hers were blank. The report imbers, type of infection, any rganism, consistent date of infection was determined to be use acquired. lacked trending or analysis of facility to determine the tion or if they had potential to in the facility. er provided information. ort identified 18 infections d received antibiotics. There sites of infection and more use of Bactroban, and t lacked consistent date of infection was determined to be use acquired. lacked trending or analysis of facility to determine the tion or if they had potential to in the facility. er provided information. ort identified 6 infections d received antibiotics. There ed sites of infection. The report ers, type of infection, any rganism, consistent date of infection was determined to be	F 4	141			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING		COM	PLETED
		245304	B. WING			12/(	01/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON F	FALLS			CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 51	F 4	41			
	the infections in the	lacked trending or analysis of facility to determine the tion or if they had potential to n the facility.					
	There was no furthe	er provided information.					
	August, September 2016:	, October and November					
	No order listing repo	ort was provided.					
	director of nursing ( month of reports dia an antibiotic stewar not aware of it and related to antibiotic DON stated the infe consistent monitorin	on 12/1/16, at 12:52 p.m. the DON) confirmed the past four dn't exist. When asked about dship program, the DON was had not implemented anything reeducation. Further, the ection control program lacked ng, trending or analysis of the ng "We have to enhance our					
	were discussed at t	v, the DON stated infections heir Monday through Friday here was not any processes ling.					
	Infection Control po received.	licy was requested but not					

Facility ID: 00758

If continuation sheet Page 52 of 52

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

F5304024

PRINTED: 01/04/2017 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' '		CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY PLETED
					1 - MAIN BUILDING 01		
NAME OF P		245304	B, WING		REET ADDRESS, CITY, STATE, ZIP CODE	11/:	29/2016
THE GAR	DENS AT CANNON F	ALLS		30	0 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K	000			
	FIRE SAFETY						
	ALLEGATION OF ( DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT C ONSITE REVISIT ( CONDUCTED TO SUBSTANTIAL CO REGULATIONS H/ ACCORDANCE W A Life Safety Code Minnesota Departn Fire Marshal Divisio dated 11-29-16, An not in substantial co requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National (NFPA) Standard 1 Chapter 19 Existing PLEASE RETURN	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. Survey was conducted by the nent of Public Safety - State on. At the time of this survey gels Care Center was found ompliance with the articipation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care. THE PLAN OF R THE FIRE SAFETY spections Division Suite 145			EPOC		
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 12/27/2016

Electronically Signed

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.

	<b>SFOR MEDICARE</b>	& MEDICAID SERVICES			OWB NO	. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• /	LE CONSTRUCTION 601 - MAIN BUILDING 01		TE SURVEY MPLETED
		245304	B. WING		11	/29/2016
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficit 2. The actual, or pr 3. The name and/or responsible for corre prevent a reoccurre This facility will be a Gardens at Cannor Center) is a 1-story The building was co The original buildin was determined to In 1982, addition w Wing that was deter construction. In 198 added to the South be Type II (111). In and was determine hour separation. The building is fully fire alarm system w detection and spac monitored for autor notification. The facility has a ca	atate.mn.us and m@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date.	K 000			

		AND HUMAN SERVICES			OMB NO.	APPROVE 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245304	B. WING		11/2	29/2016
NAME OF F	PROVIDER OR SUPPLIER			11 - I	TREET ADDRESS, CITY, STATE, ZIP CODE	
THE GAF	RDENS AT CANNON I	FALLS		-	00 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 000	Continued From pa	age 2	к	000		
	· · · ·	42 CFR, Subpart 483.70(a) is				
K 351 SS=D		r System - Installation	K 3	351		12/27/16
	Spinkler System - I 2012 EXISTING					
	construction type, a approved automati accordance with N	d hospitals where required by are protected throughout by an c sprinkler system in FPA 13, Standard for the				
	measures are pern	struction, alternative protection nitted to be substituted for				
	or local regulations In hospitals, sprink	i in specific areas where state prohibit sprinklers. lers are not required in clothes leeping rooms where the area				
	of the closet does i sprinkler coverage	not exceed 6 square feet and covers the closet footprint as 13, Standard for Installation of				
	Sprinkler Systems.	19.3.5.3, 19.3.5.4, 19.3.5.5,				
		s not met as evidenced by:			Filled opening as identified in survey with appropriate flame retardant material. Will	
	Nursing homes, an construction type, a	d hospitals where required by are protected throughout by an c sprinkler system in			monitor future projects where penetrations are made for running cables and lines.	
	accordance with N Installation of Sprin	FPA 13, Standard for the ikler Systems.			Completion 12-26-2016 Monitored by Maint. Director	
	measures are pern sprinkler protection	nstruction, alternative protection nitted to be substituted for n in specific areas where state				
	In hospitals, sprink closets of patient s	prohibit sprinklers. lers are not required in clothes leeping rooms where the area				
	sprinkler coverage	not exceed 6 square feet and covers the closet footprint as 13, Standard for Installation of				

.

Facility ID: 00758

If continuation sheet Page 3 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIPLE	E CONSTRUCTION		. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` <i>`</i>	01 - MAIN BUILDING 01		<b>IPLETED</b>
		245304	B, WING		11/	/29/2016
IAME OF	PROVIDER OR SUPPLIER	•	ST	TREET ADDRESS, CITY, STATE, ZIP COD	E	
HE GAI	RDENS AT CANNON F	FALLS		00 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
K 351 K 363 SS=D	19.4.2, 19.3.5.10, 9 On facility tour betw on 11/29/16, based revealed or based of interview that the find 1. A large opening a observed in the law This deficient pract the residents, staff compartment. This deficient pract Facility Maintenance discovery. NFPA 101 Corridor Corridor - Doors 2012 EXISTING Doors protecting correquired enclosure hazardous areas sh as those constructed core wood, or capa 20 minutes. Doors compartments are passage of smoke means suitable for There is no impedia doors. Clearance b floor covering is no latches are prohibit corridor doors and or combustible mat complying with 7.2.	19.3.5.3, 19.3.5.4, 19.3.5.5, 9.7, 9.7.1.1(1) veen 09:00 AM and 01:00 PM on observation and interview on documentation review and ndings include: around the dryer vent pipe was ndry room. ice could affect the safety of all and visitors within the tice was confirmed by the ce Director at the time of	К 363			12/27/16

Event ID: 2C8421

Facility ID: 00758

If continuation sheet Page 4 of 10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		SURVEY
		245304	B. WING		11/2	9/2016
	PROVIDER OR SUPPLIER	FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
К 363	meeting 19.3.6.3.6 Door frames shall or other materials if the smoke compar window assemblies sprinklered compa restrictions in area frames in window a 19.3.6.3, 42 CFR F and 485 Show in REMARKS protection ratings, etc. This STANDARD Corridor - Doors 2012 EXISTING Doors protecting correquired enclosure hazardous areas s as those construct core wood, or capa 20 minutes. Doors compartments are passage of smoke a means suitable ff There is no impedi doors. Clearance & floor covering is no latches are prohibi corridor doors and or combustible ma complying with 7.2 devices that releas pulled are permitte of unlimited height meeting 19.3.6.3.6 Door frames shall or other materials	are permitted. Dutch doors are permitted. be labeled and made of steel n compliance with 8.3, unless tment is sprinklered. Fixed fire s are allowed per 8.3. In rtments there are no or fire resistance of glass or assemblies. Parts 403, 418, 460, 482, 483, S details of doors such as fire automatics closing devices, is not met as evidenced by: orridor openings in other than s of vertical openings, exits, or hall be substantial doors, such ed of 1-3/4 inch solid-bonded able of resisting fire for at least in fully sprinklered smoke only required to resist the . Doors shall be provided with or keeping the door closed. ment to the closing of the between bottom of door and ot exceeding 1 inch. Roller ted by CMS regulations on rooms containing flammable terials. Powered doors .1.9 are permissible. Hold open se when the door is pushed or id. Nonrated protective plates are permitted. Dutch doors	K 36:	All Fire doors were checked and corrected so they positively latch w closed. Will check on a monthly ba ensure ongoing compliance and log to track. Completed on 12-26-2016 Monitored by Maint. Director	isis to	

ATEMEN	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	CONSTRUCTION - MAIN BUILDING 01	(X3) DAT CON	E SURVEY
		245304	B. WING		11/	/29/2016
	PROVIDER OR SUPPLIER		300	EET ADDRESS, CITY, STATE, ZIP CODE NORTH DOW STREET NNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
К 363 К 372 SS=D	window assemblie sprinklered comparestrictions in area frames in window 19.3.6.3, 42 CFR 1 and 485 Show in REMARK protection ratings, On facility tour bet on 11/29/16, base revealed or based interview that the 1 1. It was observed for the Chapel wor frame. This deficient prac the residents, staf compartment. This deficient prac the residents, staf compartment. This deficient prac Facility Maintenan discovery. NFPA 101 Subdivi Smoke Barrie Subdivision of Bui Construction 2012 EXISTING Smoke barriers sh fire resistance rati be permitted to te Smoke dampers a penetrations in ful an approved sprin	A same allowed per 8.3. In artments there are no a or fire resistance of glass or assemblies. Parts 403, 418, 460, 482, 483, S details of doors such as fire automatics closing devices, ween 09:00 AM and 01:00 PM d on observation and interview on documentation review and findings include: I that the fire separation doors uld not positively latch into the etice could affect the safety of all f and visitors within the etice was confirmed by the ice Director at the time of asion of Building Spaces - Iding Spaces - Smoke Barrier hall be constructed to a 1/2-hour ing per 8.5. Smoke barriers shall rminate at an atrium wall. are not required in duct ly ducted HVAC systems where ikler system is installed for ents adjacent to the smoke	K 372			12/27/16

Event ID: 2C8421

Facility ID: 00758

If continuation sheet Page 6 of 10

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DAT CON	E SURVEY IPLETED
		245304	B. WING		11/	29/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON I	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR( DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 372	Subdivision of Buil Construction 2012 EXISTING Smoke barriers sha fire resistance ratin shall be permitted for Smoke dampers an penetrations in fully an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. On facility tour betw on 11/29/16, based documentation rev findings include:	s not met as evidenced by: ding Spaces - Smoke Barrier all be constructed to a 1/2-hour og per 8.5. Smoke barriers to terminate at an atrium wall. re not required in duct y ducted HVAC systems where ther system is installed for nts adjacent to the smoke	К 372	Penetration was filled with appro fire resistive material. Completed 12-26-2016 Monitored by Maint. Director	opriate ,	
	office 202 for the 2 This deficient pract					
	Facility Maintenand discovery.	tice was confirmed by the ce Director at the time of sion of Building Spaces -	K 37	4		12/27/16
00-0	Subdivision of Buil Doors 2012 EXISTING Doors in smoke ba bonded wood-core	ding Spaces - Smoke Barrier arriers are 1-3/4-inch thick solid doors or of construction that ninutes. Nonrated protective				

Event ID: 2C8421

Facility ID: 00758

If continuation sheet Page 7 of 10

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		SURVEY PLETED	
		245304	B. WING		11/2	11/29/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET			
THE GAI	COENS AT CANNON P	ALLS		CANNON FALLS, MN 55009		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE	
K 374	plates of unlimited are permitted to ha assemblies per 8.5 automatic-closing, are not required to egress travel. Door clear width of 32 in doors. 19.3.7.6, 19.3.7.8, This STANDARD i Subdivision of Buil Doors 2012 EXISTING Doors in smoke ba bonded wood-core resists fire for 20 m plates of unlimited are permitted to ha assemblies per 8.5 automatic-closing, are not required to egress travel. Door clear width of 32 in doors. 19.3.7.6, 19.3.7.8, On facility tour betwo on 11/29/16, based revealed or based interview that the fi 1. It was observed to for the 100 wing wo frame. This deficient pract the residents, staff compartment.	height are permitted. Doors ve fixed fire window . Doors are self-closing or do not require latching, and swing in the direction of opening provides a minimum ches for swinging or horizontal 19.3.7.9 s not met as evidenced by: ding Spaces - Smoke Barrier rriers are 1-3/4-inch thick solid doors or of construction that ninutes. Nonrated protective height are permitted. Doors we fixed fire window . Doors are self-closing or do not require latching, and swing in the direction of opening provides a minimum ches for swinging or horizontal 19.3.7.9 ween 09:00 AM and 01:00 PM on observation and interview on documentation review and	K 374	All fire doors were checked and so they positively latch when clo check on a monthly basis to ens ongoing compliance and log kep Completed on 12-26-2016 Monitored by Maint. Director	sed. Will ure		

Facility ID: 00758

If continuation sheet Page 8 of 10

TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	• •		DATE SURVEY COMPLETED
		245304	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	11/29/2016
		FALLS	30	00 NORTH DOW STREET ANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From pa	age 8	K 374		
K 920 SS=D		al Equipment - Power Cords	K 920		12/27/16
	Extension Cords Power strips in a p used for componen- patient-care-relate (PCREE) assembli- by qualified person 10.2.3.6. Power strimay not be used for electronics), except rooms that do not PCREE meet UL 1 strips for non-PCR (outside of vicinity) care rooms, power standards. All pow precautions. Exten- substitute for fixed Extension cords us immediately upon which it was install 10.2.4. 10.2.3.6 (NFPA 99 (NFPA 70), 590.3() This STANDARD Electrical Equipm Extension Cords Power strips in a p used for compone- patient-care-relate (PCREE) assembli- by qualified person 10.2.3.6. Power s may not be used for	d electrical equipment es that have been assembled inel and meet the conditions of trips in the patient care vicinity or non-PCREE (e.g., personal of in long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power IEE in the patient care rooms meet UL 1363. In non-patient strips meet other UL ver strips are used with general nsion cords are not used as a wiring of a structure. sed temporarily are removed completion of the purpose for led and meets the conditions of ), 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5 is not met as evidenced by: ent - Power Cords and patient care vicinity are only		6 way adapter was removed from out power strip with reset replaced it. All managers and Maint. Director will mor building for compliance Completed 12-26-2016 Monitored by staff and Maint. Director	

Facility ID: 00758

If continuation sheet Page 9 of 10

		AND HUMAN SERVICES				FORM	APPROVED
10		& MEDICAID SERVICES				T	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
		245304	B. WING	—		11/2	9/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GAF	RDENS AT CANNON F	ALLS			300 NORTH DOW STREET		
				(	CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
К 920	PCREE meet UL 13 strips for non-PCRI (outside of vicinity) care rooms, power standards. All pow precautions. Exten substitute for fixed Extension cords us immediately upon of which it was installed 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3(E On facility tour betw on 11/29/16, based revealed or based of interview that the fi 1.Observations rev power strip in the k adapter was being power strip was plu This deficient pract the residents, staff compartment.	363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL er strips are used with general sion cords are not used as a wiring of a structure. ed temporarily are removed completion of the purpose for ed and meets the conditions of , 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5 veen 09:00 AM and 01:00 PM on observation and interview on documentation review and ndings include: ealed the improper use of a itchen office. A 6 way outlet used on the wall outlet and a		920			Page 10 of 10

Facility ID: 00758

If continuation sheet Page 10 of 10