DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 22, 2022

CMS Certification Number (CCN): 245304

Administrator
The Terrace At Cannon Falls
300 North Dow Street
Cannon Falls, MN 55009

Dear Administrator:

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 July 18, 2022 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

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Electronically delivered
July 22, 2022

Administrator
The Terrace At Cannon Falls
300 North Dow Street
Cannon Falls, MN 55009

RE: CCN: 245304
Cycle Start Date: May 5, 2022

Dear Administrator:

On May 24, 2022, we notified you a remedy was imposed. On July 21, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 18, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 23, 2022 be discontinued as of July 18, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of May 24, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 23, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
May 24, 2022

Administrator
The Terrace At Cannon Falls
300 North Dow Street
Cannon Falls, MN 55009

RE: CCN: 245304
Cycle Start Date: May 5, 2022

Dear Administrator:

On May 5, 2022, a survey was completed at your facility by the Minnesota Department(s) 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 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 electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 23, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 23, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 23, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Terrace At Cannon Falls will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 23, 2022. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 - Health Regulation Division 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 Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE 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 November 5, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

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.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 05/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/2/22 - 5/6/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop	E 004		6/3/22

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

Electronically Signed | 06/03/2022

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E 004	Continued From page 1 and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop and maintain a comprehensive Emergency Preparedness Program (EPP). The facility failed to ensure their EPP was reviewed and updated at least annually and that an all-hazards facility-based and community-based risk assessment was completed. In addition, the facility failed to address the resident population including, but not limited to residents most at-risk; and the type of	E 004	E004 1.The Emergency Preparedness Plan has been rewritten. A new Emergency Preparedness Plan is in place and will be updated at least annually. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk	

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E 004	Continued From page 2 services the facility has the ability to provide in an emergency. This had the potential to affect all all 38 residents and the staff of the facility. Findings include: On 5/4/22, at 1:20 p.m. during review of the facility's undated EPP, the files lacked a revision date in the last year and lacked a mechanism to document review of the plan on an annual basis. During an interview on 5/4/22, at 1:22 p.m. the environmental services director (ESD) stated he had worked at the facility for about six months and the facility EPP had not yet been fully developed. ESD agreed there was no evidence the plan had been reviewed or updated at least annually. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not current and he expected to over see the ESD to get the program running. Review of the facility document titled, The Terrace at Cannon Falls Preparedness Plan, undated, lacked policy, procedure and evidence that it was updated at a minimum annually to ensure its accuracy. See 0006: Based on interview and document review, the facility failed to ensure their EPP included an all-hazards facility-based and community-based risk assessment. See 0007: The facility failed to ensure their EPP addressed the resident population including, but not limited to residents most at-risk; the type of services the facility has, and what the facility had	E 004	Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. 5.Completion date of 06/03/22	

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E 004	Continued From page 3 the ability to provide in an emergency.	E 004		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's	E 006		6/3/22

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E 006	Continued From page 4 ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Emergency Preparedness Plan (EPP) included an all-hazards facility-based and community-based risk assessment. This had the potential to affect all all 38 residents and the staff of the facility. Findings include: On 5/4/22, at 1:20 p.m. during a review or the facility's EPP, the documents lacked a	E 006	E006 1. The All-Hazard Risk Assessment has been completed and included in the Emergency Preparedness Plan. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services	

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E 006	Continued From page 5 facility-based and community-based risk assessment, utilizing an all-hazards approach. During an interview on 5/4/22, at 1:25 p.m. the environmental services director (ESD) stated there was no such risk assessment on file and he planned to complete one. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew an all-hazards facility and community based assessment was not on file and he expected one to be completed.	E 006	and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. 5.Completion date of 06/03/22	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following:	E 007		6/3/22

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THE TERRACE AT CANNON FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009

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E 007	Continued From page 6 (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address the resident population including, but not limited to residents most at-risk; the type of services the facility has, and what the facility had the ability to provide in an emergency; in their emergency preparedness plan (EPP). This had the potential to affect all all 38 residents and the staff of the facility. Findings include: On 5/4/22, at 1:20 p.m. during a review of the facility's EPP, the files lacked information regarding the resident populations, the persons at-risk, the type of services the facility has and what the facility had the ability to provide in an emergency. During an interview on 5/4/22, at 1:26 p.m. the environmental services director (ESD) stated the above details had not been addressed. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not current and he expected to get the program running.	E 007	E007 1.The Emergency Preparedness Plan has been rewritten. A new Emergency Preparedness Plan is in place and will be updated at least annually. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. 5.Completion date of 06/03/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 05/05/2022

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

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E 013	Continued From page 7	E 013		
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 013		6/3/22

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E 013	Continued From page 8 this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop and implement policies and procedures required under CFR 483.73, to include: adequate food, and fuel would be available in case of emergency; disposal of sewage and waste in case of a disruption of water supply; evacuation of the building; sheltering in place; the use of volunteers in an emergency, or written agreements with other facilities. This had the potential to affect all 38 residents, and staff in the facility. Findings include:	E 013	E013 1.The Emergency Preparedness Plan has been rewritten and now includes policies and procedures: Ensure adequate food and water for sheltering in place. Disposal of sewage and waste. For tracking residents and staff during an emergency evacuation. Outline a means for sheltering those who cannot be evacuated. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and	

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E 013	Continued From page 9 See 0015: The facility failed to develop a emergency plan to ensure adequate food and fuel availability in the event of an emergency and the need for residents and staff to shelter in place. Additionally, the facility also failed to develop a emergency plan to ensure for the adequate disposal of sewage and waste in the event of the disruption of the facility's water source. See 0018: The facility failed to develop and implement emergency preparedness policies and procedures that included a system to track residents and both on-duty staff during evacuation in the case of an emergency. See 0022: The facility failed to develop a emergency policy or procedure which outlined a means for sheltering for all residents, staff and volunteers who would remain in the facility if an evacuation could not be executed. See 0025: The facility failed to develop and document written agreements with other providers that included pre-arranged written agreements with other facilities to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents.	E 013	completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. 5.Completion date of 06/03/222	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness	E 015		6/3/22

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E 015	Continued From page 10 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following:	E 015		

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E 015	Continued From page 11 (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an emergency plan to ensure adequate food and fuel availability in the event of an emergency and the need for residents and staff to shelter in place. Additionally, the facility also failed to develop a emergency plan to ensure for the adequate disposal of sewage and waste in the event of the disruption of the facility's water source. This had the potential to affect all 38 residents and the staff of the facility. Findings include: On 5/4/22, at 1:20 p.m. during a review of the facility's Emergency Preparedness Program (EPP), the files lacked detail on how to obtain adequate food and fuel in the event of an emergency and the need for residents and staff to shelter in place. Additionally, the facility also failed to develop a emergency plan to ensure for the adequate disposal of sewage and waste in the event of the disruption of the facility's water source. During interview on 5/4/22, at 1:26 p.m. the environmental services director (ESD) verified the EPP lacked this information. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not	E 015	E015 1.The Emergency Preparedness Plan has been rewritten and now includes policies and procedures: Ensure adequate food and water for sheltering in place. Disposal of sewage and waste. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. Completion date of 06/03/22	

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E 015	Continued From page 12 current and he expected the program to be updated soon.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the	E 018		6/3/22

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E 018	Continued From page 13 emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and	E 018		

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E 018	Continued From page 14 procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement emergency preparedness policies and procedures that included a system to track residents and both on-duty staff during evacuation in the case of an emergency, this had the potential to affect all 38 residents and staff of the facility. Findings include: On 5/4/22, at 1:20 p.m. during a review or the facility's Emergency Preparedness Program (EPP), the documents lacked a system to track the location of on-duty staff and sheltered residents that would require evacuation during an emergency. The EPP Evacuation Plan section included, "the charge person will designate one person to account for al residents and staff" but did not indicate any procedure, method or document. During interview on 5/4/22, at 1:33 p.m. the environmental services director (ESD) verified there was no tracking system established. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not current and he expected the program to be updated soon.	E 018	E018 1.The Emergency Preparedness Plan has been rewritten and now includes policies and procedures: For tracking residents and staff during an emergency evacuation. Outline a means for sheltering those who cannot be evacuated. Contains written agreements with other facilities to receive residents. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. Completion date of 06/03/22	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4)	E 022		6/3/22

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E 022	Continued From page 15 §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a emergency policy or procedure which outlined a means for sheltering for all residents, staff and volunteers who would remain in the facility if an evacuation could not be executed. This had the potential to affect all 38 residents and staff of the facility.	E 022	E022 1.The Emergency Preparedness Plan has been rewritten and now includes policies and procedures: Outline a means for sheltering in place. 2.All have the potential to be affected. The	

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E 022	Continued From page 16 Findings include: On 5/4/22, at 1:20 p.m. the facility's Emergency Preparedness Program (EPP), under the section Sheltering In Place, undated, lacked lacked information regarding specific supplies of food and fuel that would be required for sheltering in place or specific considerations given to needs of residents such as dialysis patients. During interview on 5/4/22, at 1:34 p.m. the environmental services director (ESD) verified the facility's sheltering in place policy and procedure only contained an outline and was not fully developed. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not current and he expected the program to be updated soon.	E 022	Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. Completion date of 06/03/22	
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the	E 025		6/3/22

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E 025	Continued From page 17 policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and document written agreements with other providers that included pre-arranged written agreements with other facilities to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. This had the potential to affect all 38 residents and the	E 025	E025 1.The Emergency Preparedness Plan has been rewritten and now includes policies and procedures: Contains written agreements with other facilities to receive residents. 2.All have the potential to be affected. The	

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	245304	A. BUILDING _____ B. WING _____	C 05/05/2022

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

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E 025	Continued From page 18 staff of the facility. Findings include: On 5/4/22, at 1:20 p.m. during a review or the facility's Emergency Preparedness Program (EPP), the files lacked written agreements with other providers that included pre-arranged agreements with other facilities to receive residents in the event of limitations or cessation of operations to maintain the continuity of services. The undated EPP Evacuation Plan section included to contact the Cannon Falls Superintendent to alert the school in preparation of the arrival of residents and to send their buses, to call 911 to get assistance from local and county emergency medical systems, contact St. Ansgar's Church and employees and family members would be directed to Hannah's Bend in Cannon Falls to meet the public information and liaison officer. During interview on 5/4/22, at 1:36 p.m. the environmental services director (ESD) verified there were no written agreements on file and he was not sure if these contacts were still current. The ESD added their sister facility The Terrace at Crystal should be on there, and that would be the primary place to evacuate to. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not current and he expected the program to be updated soon.	E 025	Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. Completion date of 06/03/22	
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3),	E 032		6/3/22

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E 032	Continued From page 19 §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure compliance with all applicable Federal, State and local emergency preparedness requirements in accordance with the requirements of CFR 483.73 by failing to develop policies and procedures which addressed alternative means of communication with staff and outside agencies in the event of an emergency. This had the potential to affect all 38 residents and staff of the facility. Findings include:	E 032	E032 1.The Emergency Preparedness Plan has been rewritten and now includes a primary and alternate means of communication. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk	

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E 032	Continued From page 20 On 5/4/22, at 1:20 p.m. during a review of the facility's Emergency Preparedness Program (EPP), it was revealed the facility had not updated how to address both primary and alternate means of communication that would be used with outside resources during and evacuation of the facility. During interview on 5/4/22, at 1:40 p.m. the environmental services director (ESD) stated the EPP listed a landline as an alternative means for communication, however that was not correct. The ESD verified the facility did not have an alternative means of communication established. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not current and he expected the program to be updated soon.	E 032	Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review.	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its	E 034		6/3/22

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E 034	Continued From page 21 ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies and procedures which addressed a means of providing information about the facility's occupancy needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or designee. This had the potential to affect all 38 residents who resided at the facility. Findings include: On 5/4/22, at 1:20 p.m. during a review of the facility's Emergency Preparedness Program (EPP), it was revealed the facility lacked means of providing information about the facility's occupancy needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or designee. During interview on 5/4/22, at 1:42 p.m. the	E 034	E034 1.The Emergency Preparedness Plan has been rewritten and now includes information on obtaining our current availability to take residents in during an emergency. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains	

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E 034	Continued From page 22 environmental services director (ESD) stated the EPP lacked a policy about sharing information on occupancy needs. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not current and he expected the program to be updated soon.	E 034	up to date and is not missing anything. Any issues found will be submitted to QAPI for review. Completion date 6/3/22	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to include a method for sharing appropriate information from their Emergency	E 035	E035 1.The Emergency Preparedness Plan has	6/3/22

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E 035	Continued From page 23 Preparedness Plan to the residents, family members, or representatives. This had the potential to affect all 53 residents currently residing in the facility, as well as their families and/or representatives. Findings include: On 5/4/22, at 1:20 p.m. facility's Emergency Preparedness Plan (EPP) was reviewed and did not contain a method for sharing information from the emergency plan that the facility has determined is appropriate, with residents and their families or representatives. In addition, review of the facility admission packet lacked information about the presence of the EPP. During interview 5/4/22, at 12:13 p.m. family member (FM)-A stated she had not received information from the facility regarding the facility's EPP. During interview on 5/4/22, at 12:34 p.m. social services (SS)-A reviewed the admissions packet and stated EPP information was not included, and that was not something they typically went over with residents or families upon admission. During interview on 5/4/22, at 1:42 p.m. the environmental services director (ESD) stated the EPP lacked a method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents and their families or representatives. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not current and he expected the program to be updated soon	E 035	been rewritten and now includes a method of sharing information. Information on the Emergency Preparedness Plan has been added to the Admissions packet. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. Completion date of 06/03/22	

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E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain	E 036		6/3/22

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E 036	Continued From page 25 an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan, risk assessment, policies and procedures, and to ensure the communication plan is compliant with the requirements of this section. This had the potential to affect all 38 residents, their families/representatives and the staff of the facility. Findings include:	E 036	E036 1.The Emergency Preparedness Plan has been rewritten and now includes a training and testing program. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan,	

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E 036	Continued From page 26 See 0037: The facility failed to provide staff emergency preparedness training at least annually which was based on the facility Emergency Preparedness Program (EPP). See 0039: The facility failed to provide staff emergency preparedness training at least annually which was based on the facility EPP.	E 036	Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. Completion date of 06/03/22	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility]	E 037		6/3/22

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E 037	Continued From page 27 must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 28 (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training.	E 037		

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	245304	A. BUILDING _____ B. WING _____	C 05/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 037	Continued From page 29 (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 30 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide staff emergency preparedness training at least annually which was based on the facility Emergency Preparedness Plan (EPP). This had the potential to affect all 38 residents, staff and visitors at the facility. Findings include: On 5/4/22, at 1:20 p.m. during a review or the facility's EPP, the documents lacked mention of requirements for staff emergency preparedness education and lacked education content on the current EPP. During interview on 5/4/22, at 1:26 p.m. the	E 037	E037 1.The Emergency Preparedness Plan has been rewritten and now includes a training and testing program. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will	

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E 037	Continued From page 31 environmental services director (ESD) verified there were no staff training records on file based on the facility's emergency preparedness plan (EPP). During interview on 5/5/22, at 9:30 a.m. licensed practical nurse (LPN)-B stated she had worked at the facility for greater than two years and did not recall annual emergency preparedness that was based on the facility EPP. During interview on 5/5/22, at 9:33 a.m. nursing assistant (NA)-C stated she had worked at the facility for greater than two years and did not recall annual emergency preparedness that was based on the facility EPP being done. . During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP training was not current and he expected the program to be updated soon.	E 037	review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. 5.Completion date of 06/03/22	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:	E 039		6/3/22

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E 039	Continued From page 32 (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:	E 039		

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E 039	Continued From page 33 (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or	E 039		

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E 039	Continued From page 34 man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next	E 039		

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E 039	Continued From page 35 required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency	E 039		

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E 039	Continued From page 36 event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 039	Continued From page 37 following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based	E 039		

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E 039	Continued From page 38 functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or	E 039		

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E 039	Continued From page 39 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:	E 039		

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E 039	Continued From page 40 (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct a full-scale community exercise, or a facility based exercise to test their Emergency Preparedness Program (EPP) twice per year or to document activation of their emergency preparedness plan or incident command system in response to an actual emergency event the facility experienced during the last year. This had the potential to affect all 38 residents and staff of the facility. Findings include: On 5/4/22, at 1:20 p.m. during a review or the facility's undated EPP, there was no documentation of exercises performed. During interview on 5/4/22, at 1:45 p.m. the environmental services director (ESD) verified the facility had not conducted annual emergency preparedness exercises during the last year, had not documented activation of their EPP or incident command system in response to an actual emergency event the facility experienced during the last year and had not documented an after action analysis of any facility responses to	E 039	E039 1.The Emergency Preparedness Plan has been rewritten and documentation will be kept of all exercises to test the emergency preparedness plan and/or activation of said plan. 2.All have the potential to be affected. The Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment have been rewritten and completed as required. 06/03/22 3.The Director of Environmental Services and or designee will review and update the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment at least annually. 4.The quality assurance committee will review the Emergency preparedness plan, Facility Assessment, and All-Hazard Risk Assessment annually to ensure it remains up to date and is not missing anything. Any issues found will be submitted to QAPI for review. 5.Completion date of 06/03/22	

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E 039	Continued From page 41 emergency events the facility may have experienced during the last year. During an interview on 5/5/22, at 3:49 p.m. the administrator stated he knew the EPP was not current and he expected the program to be updated soon.	E 039		
F 000	INITIAL COMMENTS On 5/2/22 - 5/6/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be unsubstantiated: H5304148C (MN82851), however; a related deficiency was cited at F609. The following complaint was found to be unsubstantiated: H5304149C (MN79639). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		6/3/22

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	245304	A. BUILDING _____ B. WING _____	C 05/05/2022

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F 580	Continued From page 42 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 43 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a provider was notifed of a change in condition for 1 of 2 residents (R8) when R8 began experiencing symptoms consistant with a urinary tract infection. Findings include: R8's Admission Record dated 2/22/19, indicated R8 had diagnoses of morbid obesity, diabetes, candidiasis of the skin and other sites (yeast infection), urinary tract infection, and urinary incontinence. R8's quarterly Minimum Data Set (MDS) dated 2/15/22, indicated R8 had intact cognition and required extensive assistance of one staff for bed mobility, toileting, and personal hygiene. R8's Order Summary Report dated 7/10/20, indicated R8 received 30 cubic centimeters (cc') of UTI heal (a supplement for the prevention of urinary tract infections) twice a day and 1 gram (GM) of Hiprex once a day for recurring UTIs. R8's Care Area Assessment (CAA) dated 11/30/21, indicated R8 triggered for urinary incontinence related to urgency and requiring	F 580	F580 1.The facility failed to ensure a provider was notified of a change in condition for one of 2 residents, R8. When R8 began experiencing symptoms consistent with a urinary tract infection. R8□s progress note dated 4/22/22 indicated that the resident was having painful urination. Then on 4/25 an order was obtained to collect urine sample. Physician ordered prophylactic antibiotic and was then changed based on urine cultures. 2.All residents have the potential to be affected. Current Floor nurses (LPN/RN) will be educated on change in condition policy and procedure by 6/3/2022 and then all new hire LPN/RN will be educated on hire. 3.DON, and unit managers will review/audit nurses charting five time a week for four weeks, then weekly for four weeks, then one time monthly once. Any issues or concerns will be brought to QUAPI. 4.The DON or designee is responsible.	

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F 580	Continued From page 44 assistance for toileting. R8's care plan dated 3/14/19, indicated R8 was frequently incontinent to urine and occasionally incontinent of bowel. R8 was on a diuretic (a cardiac medication that increases urine output). R8's progress note dated 4/22/22, at 10:27 p.m. indicated R8 stated at approximately 10:00 a.m. she began experiencing burning after voiding. R8 stated it occurred again at 11:00 a.m. 12:00 p.m. and a "couple to a few more times throughout the afternoon and again at 8:00 p.m." The note indicated the nurse would inform the oncoming overnight nurse and if the symptoms continued, they could either order a urine analysis (UA) or notify the nurse practitioner (NP)-A the next time she was at the facility. R8's progress note dated 4/25/22, at 3:16 p.m. indicated R8 complained of burning with urination. The NP was notified, and a UA was ordered. R8's progress note dated 4/28/22, at 3:56 p.m. indicated the MD had reviewed R8's UA results and ordered Macrobid (an antibiotic) twice a day for seven days. During an interview on 5/4/22, at 8:03 a.m. R8 stated she told a nurse when she began having burning pain when she urinated on 4/22/22, a Friday. R8 was unable to recall which nurse she told. R8 stated she continued to experience burning, cramping, pain, and increased urgency for three days and felt she was unable to empty her bladder. R8 stated she also told the nursing assistance (NAs) who worked that weekend but since they were from the agency, she did not	F 580	5.Date of Compliance 6/3/22	

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F 580	Continued From page 45	F 580		

know their names either.

During an interview on 5/5/22, at 12:27 p.m. licensed practical nurse (LPN)-E stated R8 only reported one symptom of burning when she urinated. LPN-E did not know if urinating every hour was frequent for R8 since she did not provide incontinent cares to R8. LPN-E also stated she was aware R8 had a history of UTI's.

During an interview on 5/5/22, at 1:31 p.m. NA-E stated she would change R8's brief approximately three times a shift. NA-E stated if R8 complained of burning and was urinating every hour, she would notify the nurse because R8 may have had a UTI.

During an interview on 5/5/22, at 1:34 p.m. registered nurse (RN)-F stated if a resident complained of burning when they urinated and they were urinating every hour, it would have been concerning for a UTI. RN-F stated when she was working on Monday, 4/25/22, she was notified that R8 was urinating frequently and had burning. RN-E stated R8 had UTIs frequently and could tell when she had one.

During an interview on 5/5/22, at 1:34 p.m. the director of nursing (DON) stated if a resident was having symptoms of increased frequency and burning when they urinated, the nurse should have reported it to the provider immediately to obtain a UA and urine culture.

During an interview on 5/5/22, at 10:45 a.m. NP-A stated R8 had "so many" UTIs and NP-A would have expected to be notified sooner than three days after R8 began having increased frequency and burning when she urinated. NP-A further

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F 580	Continued From page 46 stated she "always" tells staff to text or notify her but there were occasions that she was not notified of changes in resident conditions, and it had been an issue. The facility Change in a Resident's Condition or Status policy, undated, indicated a nurse should notify a physician or on-call physician when a resident has a significant change as defined by a condition that would not resolve itself without intervention, requires a revision to the care plan but ultimately based on judgement of the clinical staff. Except in medical emergencies, notifications were to be made within 24 hours of a change occurring in the resident's medical condition or status.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		6/3/22

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F 609	Continued From page 47 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported immediately, but no later than two hours, to the State Agency (SA) for 2 of 3 residents (R31, R34) reviewed for abuse. Findings include: An initial facility report to the SA dated 4/19/22, at 4:07 p.m. indicated on 4/19/22, at approximately 6:00 a.m. nursing assistant (NA)-D was alleged to have physically and/or mentally abused R31 and R34. The report was submitted to the SA approximately 10 hours and 7 minutes after the abuse allegations. A 5-day facility report to the SA dated 4/25/22, at 3:24 p.m. indicated the registered nurse manager was told about the allegations regarding NA-D on 4/19/22, at approximately 9:25 a.m. and an investigation started. R31's admission Minimum Data Set (MDS) dated 4/8/22, indicated intact cognition. The admission MDS indicated R31 had not rejected cares and required extensive assistance for bed mobility and total assistance with transfers. R31 had diagnoses which included end-stage renal	F 609	F609 Reporting of alleged allegations within 2 hours. Floor staff was notified by more than one resident that on the previous night shift they had allegations of alleged abuse. Floor staff failed to notify supervisor/DON within the appropriate 2 hours reporting time frame. All residents have the potential to be affected. All current facility staff members will be re-educated on abuse and neglect reporting by Social Services and or designee. The Social Services or designee will review/audit all OHFC reports to ensure timely reporting for each submitted OFHC report. Any future issues with reporting will be brought to QAPI. The ED or designee will be responsible. Date of Compliance 6/3/22	

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F 609	Continued From page 48	F 609		

disease, depression and cataracts, glaucoma or macular degeneration.

During an interview on 5/3/22, at 2:38 p.m. R31 stated during the night shift around 4/19/22, her bedside table tipped over. R31 stated NA-D scolded her while cleaning up the spilled tray contents, shut off her television and told R31 she needed to go to sleep. R31 stated she told the day staff about it and NA-D has since not returned to work.

R34's admission MDS dated 3/22/22, indicated moderately impaired cognition. The admission MDS also indicated R34 had not rejected cares and required extensive assistance for bed mobility and transfers. R34 had diagnoses which included arthritis, post-traumatic stress disorder and manic depression.

During an interview on 5/3/22, at 2:45 p.m. R34 stated during the night shift around 4/19/22, NA-D transferred her to bed too fast and was rough. R34 stated she reported it to the day staff and NA-D has since not returned to work.

During an interview on 5/4/22, at 8:56 a.m. NA-C stated R31 and R34 had complained about NA-D during morning cares on 4/19/22, between 6:00 a.m. and 7:00 a.m. NA-C stated she reported it immediately to the day shift nurse who then went in to assess the residents. NA-C stated she also reported the allegation to the nurse manager around 9:30 a.m.

During an interview on 5/5/22, at 1:34 p.m. the director of nursing (DON) stated the above allegations were not reported to SA within the two-hour timeframe and should have been.

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F 609	Continued From page 49 The facility policy Abuse Prevention Program dated 12/8/21, indicated allegations involving abuse must be reported to the SA immediately, but no later than two hours after it occurs.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to complete a safe smoking assessment for 1 of 2 residents (R29) who smoked at the facility. Additionally, the facility failed to comprehensively assess each fall and identify causative factors to determine the reason for falls and identify potential effective interventions to decrease the risk for future falls for 1 of 3 residents (R15) reviewed for accidents. Findings include: R29's admission Minimum Data Set (MDS) dated 4/17/22, indicated she had intact cognition. The MDS further indicated R29 was independent with transfers and needed limited assistance with walking both in the room and in the corridor. R29 had diagnoses of nicotine dependence, cancer and respiratory failure.	F 689	F689 Free of Accidents, Hazards/Supervision Devices. Upon admission R29 states she was a nonsmoker and intended to stay nonsmoking. Later R29 stated at her care conference that she was going outside daily to smoke. R29□s smoking status was not updated, and smoking assessment was not completed. Additionally, the facility failed to comprehensively assess each fall and identify causative factors to determine the reason for falls and identify potential affective interventions to decrease the risk for future falls. All residents have the potential to be affected. Social Services or licensed staff (RN/LPN) in her absence will complete	6/3/22

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F 689	Continued From page 50 R29's Smoking Review form dated 4/18/22, indicated R29 was not a smoker and intended to stay non-smoking. R29's Care Conference form dated 4/28/22, indicated R29 went outside daily to smoke. During an observation and interview on 5/2/22, at 2:22 p.m. R29 had a pack of cigarettes and disposable lighter on her bed. R29 stated she smoked and was able to keep her cigarettes and lighter with her, but no one had talked to her about smoking policies at the facility. During observation on 5/2/22, at 2:39 p.m. R29 left her room, went outside the front of the facility smoking area, lit a cigarette with her lighter and smoked it. During interview on 5/2/22, at 2:53 p.m. licensed practical nurse (LPN)-B stated R29 was a smoker. LPN-B stated a resident should be assessed to determine if they were a safe smoker. LPN-B reviewed R29's medical record and stated R29's smoking assessment should have been updated to reflect current smoking status and was not. During an interview on 5/2/22, at 5:37 p.m. social services (SS)-A stated R29 had not been reassessed when her smoking status changed and should have been for safety purposes. During an observation on 5/2/22, at 5:47 p.m. SS-A was outside with R29 completing a smoking assessment. During a follow-up interview on 5/2/22, at 6:17 p.m. R29 stated she just learned from the	F 689	smoking assessment within 24 hours of re/admission and upon notification of new smoking status by 6/3/2022. Re/Admission checklist will be updated with task for smoking assessment to be completed by 6/3/2022. Additionally, all licensed staff (RN/LPN) will be educated on the risk management policy and procedure by 6/3/2022. Smoking assessments will be reviewed/audited by MDS or designee upon re/admission, quarterly, annually, and in significant change in resident's status. Additionally, fall risk managements will be reviewed/audited by DON and or designee five time a week for four weeks, then weekly for four weeks, then one time monthly once or until substantial compliance is met. . Any issues or concerns will be brought to QAPI. Person responsible is the DON or designee.	

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F 689	Continued From page 51	F 689		

smoking assessment with SS-A that her lighter needed to be kept with the nurse and residents could not borrow cigarettes or lighters from other residents.

During interview on 5/5/22, at 1:34 p.m. the director of nursing (DON) stated residents should be assessed for smoking safety and reassessed if there was a change. DON further stated, residents should store lighters at the nurse's carts.

The facility Smoking Policy - Residents Copy, undated, indicated prior to, or upon admission residents would be informed about any limitations on smoking, including designated smoking areas, and the extent to which the facility could accommodate smoking or non-smoking preferences.

R15's Admission Record dated 2/11/22, indicated R15 had diagnoses of Parkinson's, diabetes, failure to thrive, cataracts in both eyes, disorientation, breast cancer, and a history of falls.

R15's significant change Minimum Data Set (MDS) dated 4/19/22, indicated R15 had severe cognitive deficits and had wandered 1 to 3 days during the assessment period. No other behaviors noted during the assessment period. R15 required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene. R15 was not steady and only able to stabilize herself with assistance while transferring from surface to surface, walking, and standing from a seated position.

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R15's Care Area Assessment (CAAs) dated 4/20/22, indicated R15 triggered for decreased cognition/dementia. R15 had visual disturbances related to cataracts and diabetic retinopathy (damage to blood vessels in the eyes leading to blindness). R15 triggered for wandering however no further indications or interventions were check boxed. R15 also triggered for falls related to impaired balance and antipsychotic and antidepressant medications, irregular heart rhythms, Parkinson's and cognitive impairment. The CAAs indicated R15 had fallen once since admission or prior assessment.

R15's care plan dated 2/11/22, indicated R15 was admitted to the facility for long term care following a fall at home. Interventions including one staff member assisting R15 with ambulation and transfers. R15 was at risk for wandering due to cognitive impairment and on 3/20/22, was placed on 15 minute checks for wandering. The care plan also indicated R15 was a high risk for falls with a goal that R15 would not sustain serious injury. Interventions included anticipating R15's needs, keeping the call light within reach and answering R15's needs promptly. On 3/2/22, interventions to maintain a safe environment clear of clutter and personal items within reach was added to R15's care plan. After 3/2/22, the care plan lacked any revisions or new interventions although R15 had multiple falls resulting in two hospital evaluations and stitches.

R15's Order Summary Report dated 5/5/22, indicated R15 was to be monitored for antipsychotic medication side effects such as an increase in falls and restlessness.

R15's progress notes regarding falls were as

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F 689	Continued From page 53 follows: -3/25/22, at 5:45 p.m. R15 heard yelling for help from her room. R15 was found on the floor in front of her door with a "moderate" amount of blood pooled on the floor and on R15's left forehead. R15 sent to the hospital for evaluation and stitches to left brow. -3/29/22, at 6:35 p.m. R15 found on her hands and knees in the dining room after another resident found her. -4/3/22, at 10:54 p.m. R15 found lying on the floor at the end of her bed. R15 did not recall how are where she fell but that she was looking for her family. R15 had a small scrape on her right arm. -4/16/22, at 11:53 a.m. R15 was sitting in her wheelchair in the dining room when resident stood up and began walking by the kitchen cabinets. As staff went to get wheelchair for R15, R15 fell to the floor, landing on her buttocks and hitting her elbow on a cabinet door. -4/30/22, at 8:58 p.m. R15 attempted to stand up from her wheelchair then fell forward landing on her front side. R15's face hit the floor and the wheelchair pedals were under R15's hips. R15 was mechanically lifted back into her wheelchair and brought to the nurse's station to be cleaned up. R15 had "a lot of swelling" to her lip, a cut on her upper lip, an abrasion under her left eye and swollen nose. R15 sent to the hospital for evaluation and stitches to her lip. -5/3/22, at 3:14 p.m. R15 found sitting on the floor with her wheelchair behind her with no injuries noted. R15 had been sitting in her wheelchair prior to the fall. R15's risk management assessments were as follows: -3/25/22, indicated no injuries observed although R15 had a laceration that required stitched at the	F 689		

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F 689	Continued From page 54 hospital. R15's mental status was alert and oriented to person. The documentation lacked any other assessment including pain, mobility, predisposing environmental, physiological, situational factors, or new interventions. -3/29/22, lacked any documentation regarding mental status, pain, mobility, predisposing environmental, physiological, situational factors or new interventions. -4/3/22, indicated R15 was confused and oriented to person only. The assessment indicated R15 had no injuries although R15 had a small scrape to her right arm. The documentation lacked any other assessment including pain, mobility, predisposing environmental, physiological, situational factors, or new interventions. -4/16/22, lacked any documentation regarding mental status, pain, mobility, predisposing environmental, physiological, situational factors or new interventions. -4/30/22, indicated no injuries were observed although R15 had a swollen and cut lip that required stitches at the hospital, a swollen nose and abrasion under her left eye. The documentation lacked any new interventions to prevent R15 from future falls. -5/3/22, lacked any documentation regarding mental status, pain, mobility, predisposing environmental, physiological, situational factors or new interventions. R15's NA Kardex dated 5/5/22, indicated R15 was on 15 minute checks for elopement but lacked any interventions to prevent R15 from falls such maintaining her bed in the lowest position or bringing her to the nurse's station for observation during periods of restlessness. Although R15 had fallen six times in 39 days,	F 689		

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F 689	Continued From page 55	F 689		

documentation lacked a comprehensive assessment and/or root cause analysis to identify R15's afternoon restlessness and subsequent falls. Additionally, documentation lacked revised or new interventions to prevent further falls from occurring.

During an observation on 5/2/22, at 1:30 p.m. R15 was asleep in bed. R15's bed was not in the lowest position. R15 had a large bruise on the left side of her jaw and chin and a swollen left upper lip.

During observation on 5/2/22, at 5:58 p.m. R15 asleep in bed and the bed not in lowest position.

During observation and interview on 5/2/22, at 6:01 p.m. nursing assistant (NA)-H entered R15's room. NA-H stated R15 had fallen a few days ago, was confused and would attempt to get out of bed. NA-H stated R15's bed was to be lowered to the ground and her call light available. R15 would also occasionally be brought to the nurse's station for observation. NA-H then lowered R15's bed to the lowest position.

During an interview on 5/4/22, at 11:59 a.m. NA-E stated she was unaware if there was a reason for R15's multiple falls. R15 spoke often about wanting to go home and had been on 15 minute checks by the NAs for "weeks". NA-E was not aware of any other interventions in place to prevent R15 from falling. NA-E further stated there was no NA care sheet and resident cares were only found online; therefore, agency staff would need computer access to know how to care for residents.

During an interview on 5/4/22, at 12:03 p.m. NA-I

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F 689	Continued From page 56	F 689		

stated R15 often tried to get up by herself and had been on 15 minute checks since she had been working at the facility for two weeks. NA-I stated she did not know of any other interventions to prevent R15 from falling.

During an observation on 5/5/22, at 2:31 p.m. R15 was observed aggressively propelling herself down the hallway, in her wheelchair, by grabbing the railing on the wall with her right hand. R15 was unaccompanied and stopped when she came to two doors where there was no railing. R15 then fell asleep in her wheelchair in the hallway. At 2:34 p.m. NA-G walked past R15 without interaction. At 2:36 p.m. multiple staff approached R15 to wake her and wheel her back down the hallway.

During an interview on 5/5/22, at 11:48 a.m. registered nurse (RN)-C stated when a resident had an unwitnessed fall, the nurse would assess the resident for injury and begin neurological assessments if the resident may have hit their head. The nurse would also complete a risk management report and include interventions to prevent future falls based on the circumstances, however, a root cause analysis would not necessarily be completed, and no interdisciplinary team (IDT) met to discuss root cause analysis for residents who fell. RN-C stated R15 fell often, and she believed she was on frequent checks and had anti-rollback bars on her wheelchair but was unaware of any other interventions in place to prevent R15 from future falls.

During an interview on 5/5/22, at 1:52 p.m. the director of nursing (DON) stated when a resident had multiple falls the IDT team, who met daily, would discuss the possible cause, and update the

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F 689	Continued From page 57 resident care plan with new interventions if necessary, however, the IDT did not keep a record of the meetings. The DON stated the resident's nurse would complete a risk management form and include interventions at the time of the incident. The DON further stated R15 had had a cognitive decline and became agitated and confused. During an interview on 5/5/22, at 10:30 a.m. nurse practitioner (NP)-A stated R15 had had multiple falls and was a challenge because of her anxiety and Parkinson's. The NP stated she often gets confused with delusions. R15's behaviors usually increase in the evening and present as "sundowning" (increased aggression, anxiety, and confusion that occurs in the late afternoon and continuing into the night). NP-A stating keeping R15 at the nurse's station or offering her snacks may help decrease her anxiety and behaviors although there was no mention of either intervention in R15's care plan or NA Kardex. The facility Falls-Clinical Protocol policy, undated, indicated staff should attempt to define possible causes of a fall within 24 hours. The staff and physician were to identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment until falling reduces or stops or until a reason is identified. Staff were to monitor and document the resident's response to interventions and if a resident continued to fall, re-evaluate the relevance of current interventions.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		6/3/22

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F 690	Continued From page 58 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 690	F690 Bowel and Bladder, Catheter,	

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F 690	Continued From page 59 review, the facility failed to provide physician's diagnosis and continued need for an indwelling urinary catheter for 1 of 2 residents (R25) and failed to ensure that a urine drainage bag was kept off the floor for 1 of 2 residents (R35) reviewed for catheter care. Findings include: R25's admission Minimum Data Set (MDS) dated 3/10/22, indicated R25 had intact cognition, needed extensive assist with toileting and hygiene and did not have an indwelling catheter. Diagnoses indicated type II diabetes mellitus with diabetic chronic kidney disease. R25's Discharge Return Anticipated MDS dated 3/20/22, indicated the discharge was unplanned to an acute care hospital. R25's Prospective Payment System (PPS) 5-day scheduled assessment, dated 4/3/22, indicated R25 needed total assistance with toileting, extensive assistance with hygiene and had an indwelling urinary catheter. R25's face sheet Diagnosis Information, printed on 5/5/22; did not indicate indwelling catheter or diagnosis for catheter. R25's Order Summary Report, printed on 5/5/22, indicated the following orders: -4/11/22, Change foley drainage bag on evening shift every Monday -4/11/22, Foley catheter output every shift -4/23/22, Change foley catheter every month. Use 16 fr. (french) coude (curved tip or slightly angled catheter) with 10 cc balloon.	F 690	Incontinence, UTI related to R25 and R35. Staff failed to provide a medical diagnosis and continued need for indwelling catheter and failed to ensure a urinary drainage bag was kept off the floor. All residents have the potential to be affected. All residents with an indwelling catheter will have their diagnosis list reviewed for the appropriate need for an indwelling catheter. If an appropriate diagnosis is unavailable, then staff will notify the facility MD to make a referral with urology. Additionally, nursing staff will be educated on the indwelling catheter care policy and procedure. DON or designee will complete weekly audits for four weeks to ensure that all urinary drainage bags contain a privacy bag. Compliance date 6/3/22 The DON or designee will be responsible.	

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F 690	Continued From page 60	F 690		

R25's care plan dated 3/13/22, indicated R25 was incontinent of bowel and bladder, was to be checked and changed every two hours and R25 used a graduated cylinder for a urinal. The care plan lacked detail for indwelling catheter care.

During observation on 5/2/22, at 6:32 p.m. R25 was noted to have a urinary catheter leg bag attached to his bed frame.

During interview on 5/5/22, at 3:03 p.m. licensed practical nurse (LPN)-B stated R25 was in the hospital about a month ago for scrotal cellulitis and had a catheter placed. LPN-B reviewed R25's care plan and diagnosis list and stated the medical record should have been updated to reflect diagnosis and indication for catheter and had not been.

During interview on 5/5/22, at 3:21 p.m. R25 stated he had a catheter placed in the hospital because he would "urinate all over".

During interview on 5/5/22, at 3:22 p.m. the director of nursing (DON) stated residents with a catheter should have a diagnosis and indication for use.

R35's face sheet dated 5/6/22, identified R35 had severe cognitive impairment with traumatic brain injury, history of urinary retention, mood disorder, and seizures.

R35's care plan dated 4/19/21, identified R35 required an indwelling urinary catheter related to neuromuscular dysfunction (loss of muscle control).

During observation 5/2/22, at 6:44 p.m. R35 was

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F 690	Continued From page 61 lying down in bed and R35's urine drainage bag and tubing were on the floor without a barrier placed between the drainage bag and the floor. During observation on 5/3/22, at 8:41 a.m. R35 was sitting in her wheelchair in the dining room. R35's urinary drainage tubing was outside of it's protective cover and was lying touching the floor. During observation on 5/3/22, at 1:53 p.m. R35 was lying in bed and R35's urine drainage bag was non-dependent and positioned at the a level equivalent to her bladder. During interview on 5/3/22, at 2:13 p.m. nursing assistant (NA)-E confirmed R35's urine drainage bag was at the same level as her bladder while she laid in bed. NA-E stated there was a risk for a bladder infection because contaminated urine was able to back flow into R35's bladder. NA-E stated R35 did not have a protective cover for the drainage bag in the room. NA-E stated in an effort to prevent the drainage bag from touching the floor, she had no choice but to place it on the bed next to her. During interview on 5/3/22, at 2:37 p.m. registered nurse (RN)-C confirmed non-dependent drainage could cuase urine to flow back into the bladder and backflow of urine could introduce new bacteria into the bladder and place R35 at risk developing an urinary tract infection. During observation on 5/4/22, at 7:04 a.m. R35 lying in bed and her urine drainage bag and tubing resting directly on the floor. During observation and interview on 5/4/22, at	F 690		

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F 690	Continued From page 62 1:45 p.m. R35 was lying in bed withe her urinary drainage bag positioned on the floor between R35's bed and the wall. NA-E stated if R35 had rolled over in bed, she could have accidently pulled out her foley catheter. NA-E added, R35 had a higher risk for developing an infection because the drainage bag was on the floor without a protective cover. During interview on 5/6/22, at 8:54 a.m. the DON stated R35 could develop a bladder infection with her drainage bag and tubing lying directly on the floor. DON stated the expectation is drainage bag must be placed into a protective cover. In addition, the DON stated placing R35's drainage bag on top of her bed could cause a back flow of urine into her bladder and place R35 at a higher risk for developing a bladder infection. The facility policy Catheter Care, Urinary not dated, identified steps to prevent a catheter related urinary tract infection. Staff will review each resident's care plan for specific catheter care instructions. Urine drainage bags must be positioned below the level of the bladder for appropriate drainage and to prevent a back flow. Infection control precautions listed in the facility policy instructed staff to never place a catheter tubing and drainage bag on the floor. The policy lacked detail regarding physician's diagnosis and assessing continued need for an indwelling urinary catheter.	F 690		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		6/3/22

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F 760	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 1 residents (R21) reviewed for insulin administration. Findings include: R21's annual Minimum Data Set (MDS) dated 4/1/22, indicated R34 had moderately impaired cognition and a diagnosis of diabetes mellitus (A disease in which the body has high blood sugar levels for prolonged periods of time). R21's Order Summary Report printed 5/5/22, indicated an order for insulin aspart solution (diabetes management medication) 100 units/milliliter. Inject as per sliding scale with a start date of 4/29/22. During an observation on 5/5/22, at 12:00 p.m. registered nurse (RN)-B checked R21's blood sugar. RN-B removed R21's insulin aspart pen from the medication cart, removed the cap and dialed seven units of insulin. RN-B then cleaned the top of the insulin pen with an alcohol wipe and opened a new insulin needle and placed the needle on the pen. RN-B entered R21's room and administered the insulin without first priming the insulin needle. During an interview on 5/5/22, at 12:16 p.m. RN-B verified she dialed up seven units of insulin prior to placing an insulin needle on the insulin pen and had not primed the insulin needle with two units of insulin and then dialed up the prescribed insulin dose. RN-B stated she had	F 760	F760 Residents are free of significant medication errors, review of insulin administration. A staff failed to prime insulin pen with two units of insulin and then dial up to the prescribed insulin dose prior to administration of the insulin. All residents have the potential to be affected. All licensed staff (RN/LPN) will be educated on proper insulin pen administration. DON or designee will review/audit licensed staff's (RN/LPN) insulin pen administration twice weekly and then weekly for two weeks with a compliance date of 6/3/2022. DON or designee will be responsible.	

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F 760	Continued From page 64 "checked" at one time and priming was not needed but was unable to identify the source. During an interview on 5/5/22, at 12:24 p.m. RN-C stated insulin pen needles need to be primed with two units of insulin and then dialed up to the prescribed insulin dose. During an interview on 5/5/22, at 12:29 p.m. licensed practical nurse (LPN)-B stated insulin pen needles need to be primed with two units of insulin and then dialed up to the prescribed insulin dose. During an interview on 5/5/22, at 1:08 p.m. consultant pharmacist (CP) stated insulin pen needles need to be primed with two units of insulin and then dialed up to the prescribed insulin dose. During an interview on 5/5/22, at 1:34 p.m. the director of nursing (DON) stated insulin pen needles need to be primed with two units of insulin and then dialed up to the prescribed insulin dose to ensure the resident received the correct amount. Insulin Safety Pen Needle Instructions for Use document provided 5/5/22, indicated to first dial up two units to prime the needle, then dial up the prescribed insulin dose.	F 760		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of	F 803		6/3/22

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F 803	Continued From page 65 residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the weekly menu was followed and food preferences were honored for 2 of 3 (R8, R239) residents reviewed for dining. Findings include: R8's Admission Record dated 5/5/22, indicated R8 had diagnoses of morbid obesity with low oxygen exchange due to excess calories, diabetes, major depression, anxiety, candidiasis (fungal infection) of the skin and nails, urinary tract infections, low iron and vitamin D levels, high cholesterol, celiac disease (chronic immune	F 803	R8: R8□s ticket will be updated to make more sense to her and kitchen staff, DD will do an education about the different diets offered at the facility, Meals will be served after or during drink distribution to get drinks and meals to residents at relatively the same time, DD will talk to resident about likes, dislikes, and preferences. DD will also talk to R8 about foods she likes for her gluten free diet and attempt to provide. A notice will be given to all residents if there is a menu change before meal service. R239: Kitchen staff will offer any	

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F 803	Continued From page 66 disorder triggered by gluten ingestion causing damage to intestinal lining, diarrhea, fatigue, bloating, and anemia). R8's quarterly Minimum Data Set (MDS) dated 2/15/22, indicated R8 had intact cognition, felt tired or had little energy for 2-6 days, and poor appetite or overeating 7-11 days during the assessment period. R8's care plan dated 3/13/19, indicated R8 had a nutrition risk related to celiac disease, high cholesterol, obesity, diabetes, depression, high blood pressure, and anxiety. Interventions included reinforcing the importance of maintaining the ordered no salt added and low fat diet. R8's Physician Orders dated 8/9/22, indicated R8 was on a gluten free, NAS (no added salt), low fat diet. R8's meal preference card dated 5/5/22, indicated R8 had an allergy to wheat (gluten) and included, "Dislikes: Onion, cooked-visible; onions, raw; tomatoes, fresh. Special Notes: Nothing with wheat in it, gluten free. dislikes: tomatoes, peaches, donuts, muffins, no mayo on burgers, no liver...likes guten [sic] free donuts, muffins, Dislikes, tomatoes, onions, tilapia fish, no tomato soup pickles likes, cod fish, lettuce, (KETCHUP WITH FRIES)" During an interview on 5/2/22, at 3:23 p.m. R8 stated she had celiac disease and it had been difficult to get meals she enjoyed that were gluten free. R8 stated she often received broccoli which, although she liked, she often tired of. The only alternative to the daily vegetable was tomato juice	F 803	condiments that make sense based on meal on all resident meal trays as well as having a tray in the delivery carts with other seasonings and condiments they may request, meals will not be delivered before drinks, DD will talk to R239 about food likes, dislikes, and preferences. Menu will be updated to reflect bread being available upon request instead of with every meal. Care conference preference sheets will be updated with any new preferences that are brought up. All residents have the potential to be affected. Dining staff were educated on the importance of insuring that drinks are served prior to meals and the necessity of accurate menus and resident preference. Talk to affected residents about their likes, dislikes, and preferences, update their meal preference sheets, assure R8 that she is receiving Gluten Free items and talk to her about ideas to get her meals she may enjoy more. Meals will not be served before drinks. Condiments will be made available to residents on trays and upon request. Bread will be offered upon request, and this will be reflected on menus. Preferences will be updated as they are mentioned or brought up by residents. Trays will be monitored for missing items to assure residents are getting what they need and/or want. Dining audits will be done 5 days a week for 1 month, and	

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F 803	Continued From page 67 (V8) which R8 did not like. R8 stated the facility had run out of gluten free noodles and had not ordered more for her. She was also served beef and barley soup, however, barley contains gluten and she was unable to eat it. R8 stated the staff don't understand the limitations and restrictions of her diet. During an interview on 5/3/22, at 9:09 a.m. R8 stated she was able to self-administer her medications, but it was difficult to take them with her meal because the drinks were often served after she finished her meal. During an interview and observation on 5/4/22, at 8:50 a.m. R8 was in bed eating breakfast. R8 was served bacon but stated she had asked for no bacon because it "is all fat". R8 ate half of three strips of bacon lengthwise to avoid the fat on the other half of the bacon strip all though R8 was on a low sodium, low fat diet. R8 stated she used to write notes on the meal preference card, but the cooks would never get it, so she stopped trying. R8 also stated the meal preference card was so confusing she couldn't understand what it was listing as her likes or her dislikes, so she didn't expect the kitchen staff to understand it either. During an observation and interview on 5/4/22, at 12:11 p.m. R8 was served a tuna sandwich and mashed potatoes. R8 stated she had also requested the daily vegetable of green peas but had not received them. R8 was also served chocolate pudding instead of the chocolate and vanilla swirl pudding that was listed on the menu for dessert. During an interview on 5/4/22, at 12:28 p.m. p.m. cook (CK)-C stated she was told R8 did not want	F 803	once week for 2 months or until compliance is met. Any concerns will be brought to the QAPI for review. Date of implementation: June 3nd, 2022 Who was responsible for making the corrections: Dietary Director or designee	

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F 803	Continued From page 68	F 803		

the peas served with her lunch, however, after reviewing R8's meal preference card, verified that R8 had ordered the peas and would send a bowl to R8's room.

R239's Admission Record dated 5/5/22, indicated R239 had diagnoses of protein calorie-malnutrition, diabetes, dementia, alcohol abuse, stroke, and failure to thrive.

R239's significant change MDS dated 4/24/22, indicated R8 had mild cognitive deficits and had little pleasure or interest in doing things for 2-6 days during the assessment period.

R239's Care Area Assessment (CAA) dated 4/25/22, indicated R239 triggered for psychosocial well-being and had little pleasure or interest in doing things related to mood and dementia.

R239's care plan dated 3/17/22, indicated R239 had impaired cognition related to Alzheimer's and alcohol abuse. Interventions included using yes/no questions.R239 also had a potential for pressure ulcers related to poor nutrition.

R239's Physician Orders dated 3/14/22, indicated R239 received a multivitamin-minerals tablet once a day for failure to thrive and thiamine 100 miligrams once a day for failure to thrive and chronic alcohol use.

R239's Care Conferences food preference form, undated, indicated R239 prefered Raisin Bran cereal.

During an observation and interview on 5/3/22/, at 9:14 a.m. R239 stated he did not get salt or

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F 803	Continued From page 69	F 803		

pepper and did not eat his pancakes that morning because he did not get any butter or syrup. R239 stated nursing assistant (NA)-G delivered drinks 30 minutes after breakfast was served but R239 stated the pancakes were cold and it would take too long to heat them up and get the syrup so he told NA-G not to bother. R239 also stated he would prefer to have his beverages served before or with his meal and not after he had finished eating. NA-C entered R239's room and verified R239 had not eaten his pancakes and there was no syrup, butter, salt or pepper served with his meal.

During an interview on 5/3/22, at 9:23 a.m. NA-G stated beverages were served after the residents received their meals by the NAs or dietary aides (DAs) and varied depending on the availability of the staff.

During an interview and observation on 5/4/22, at 8:37 a.m. R239 stated he was waiting for his breakfast and would see what they delivered. R239 stated he did not like the oatmeal and was not offered a choice of cereal although it was listed on the menu. R239 stated they made Raisin Bran once and he liked that, but it was only offered one time.

During an interview on 5/4/22, at 12:13 p.m. R239 stated although the menu indicated bread would be served with every meal, he "never" got bread and would like to have it. R239 also verified he received chocolate pudding instead of the chocolate vanilla swirl pudding that was listed on the menu for dessert.

During an interview on 5/4/22, at 12:23 p.m. CK-C stated although the menu indicated bread

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F 803	Continued From page 70 was served with every meal, they had not served bread with the meals. CK-C also verified that there was no vanilla pudding available for the chocolate and vanilla pudding swirl. CK-C also stated that Raisin Bran was available daily as a cereal option but she did not think R239 liked cereal although it was listed on his Care Conference food preference sheet. During an interview on 5/4/22, at 1:10 p.m. the dietary director (DD) stated although the vanilla pudding was delivered on 5/2/22, she had not notified the residents it would not be included in the dessert on 5/4/22. The DD also stated although the menu indicated bread was served with every meal, bread had not been served with meals since she began working at the facility in September 2021. During an interview on 5/5/22, at 10:56 a.m. nurse practitioner (NP)-A stated it was important for residents, to receive food they preferred, if available, for their health and psychosocial wellbeing. NP-A stated R239 had a diagnosis of failure to thrive, and it was concerning that he refused to eat a meal because the condiments weren't provided or he wasn't offered his known preferences such as Raisin Bran cereal, to maintain a healthy weight. The facility Serving Food policy dated December 2013, indicated staff were to check for missing items when delivering resident meal trays.	F 803		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a	F 838		6/3/22

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F 838	Continued From page 71 facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy,	F 838		

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F 838	Continued From page 72 pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure that the facility assessment was reviewed and updated annually. This had the potential to affect all 38 residents who resided in the facility. Findings include: Review of the 9/10/19, Facility Assessment identified there was no indication that the facility assessment had been reviewed annually or as necessary to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. During an interview on 5/5/22, at 3:49 p.m. the administrator confirmed the facility assessment had not been reviewed or updated since 2019	F 838	F838 Facility Assessment. The facility failed to update the annual facility assessment. All residents and staff have the potential to be affected. The department heads will be in-serviced on the facility assessment on 6/2/22 to ensure it accurately reflects the needs of our residents and who we provide care. The ED or designee will review/audit for compliance, audits will be completed weekly for four weeks, then monthly for two months or until substantial compliance is met. Any issues or concerns will be brought to QUAPI. The ED or designee is responsible for the	

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F 838	Continued From page 73 and should have been.	F 838	correction. The facility assessment will be updated as needed. Any issues will be brought to QAPI. Compliance Date 6/03/22	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		6/3/22

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F 880	Continued From page 74 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure staff wore	F 880	F880 Infection prevention and Control. Staff failed to ensure staff wore	

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F 880	Continued From page 75 appropriate personal protective equipment (PPE) according to the Center for Disease Control and Prevention (CDC) guidelines for a facility with a county transmission rate of "high". The facility failed to ensure staff utilized PPE appropriately for 1 fo 2 residents who were on transmission based precautions (TBP). The facility failed to ensure infection control policies were reviewed and/or revised annually to reflect current standards of practice and CDC guidelines. Additionally, the facility failed to ensure ongoing surveillance to identify, interpret and analyze community and facility aquired infections and communicable disease outbreaks in the facility. These deficient practices had the potential to affect all 38 residents, staff and visitors in the facility. Findings include: R25's Prospective Payment System (PPS) 5-day scheduled assessment, dated 4/3/22, indicated R25 required total assistance with bed mobility, transfers and toileting. R25 required extensive assistance with dressing and hygiene and had an indwelling urinary catheter. R25 had one unstageable pressure ulcer and three venous or arterial ulcers. R25's face sheet Diagnosis Information form printed 5/5/22, lacked a diagnosis of MRSA (an infection caused by a type of staph bacteria that has become resistant to many antibiotics) and VRE (bacteria that developed resistance to vancomycin, an antibiotic that is used to treat some drug-resistant infections). R25's Order Summary Report, printed on 5/5/22, indicated the following orders: 3/29/22, Contact	F 880	appropriate PPE according to CDC recommendations for a facility with a county with high transmission rate. Facility failed to ensure staff utilized PPE appropriately for 1-2 residents who were on transmission based precautions. Facility failed to ensure infection control policies were reviewed and/or revised annually to reflect current standards and practices. Facility failed to ensure ongoing surveillance for infectious disease facility acquired infections and communicable disease. Facility failed to wear appropriate PPE when the transmission rate is high in this county. Facility failed to update mandatory Covid vaccinations policy to include the CDC and CMS requirements. Policy also lacked procedure for staff who are not up to date with their Covid vaccinations including their routine testing. All residents and staff can be affected. The facilities health care worker vaccination policy will be updated to reflect the CDC and CMS recommendations. Routine testing will be provided based on county Covid transmission rates. Policy and procedure for facility staff and residents will be updated to be in compliance with CDC and CMS recommendations. All staff will be reeducated on droplet and contact precautions, including how to appropriately Don/doff PPE by compliance date of 6/3/2022 and/or prior to the start of next scheduled work date. Facility staff will complete twice weekly	

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F 880	Continued From page 76 precautions: MRSA and VRE in urine and wounds. R25 ' s care plan dated 3/29/22, indicated R25 had MRSA and VRE in urine and wounds. The care plan directed staff to follow contact isolation: wear gowns and masks when changing contaminated linens. During an observation on 5/2/22, at 7:02 p.m. R25's room had a personal protective equipment (PPE) bin outside the room containing gowns and gloves. There was a sign posted on the door which indicated contact precautions were in place which included the need to wear gloves, eye protection, mask and a gown with resident contact. Nursing assistant (NA)-A and NA-B were in R25's room at the bedside. Both had on eye protection and face mask. Neither NA-A nor NA-B had on gowns. NA-A put on gloves, removed a pillow that was under R25's left arm and another pillow that was under his legs. A moderate amount of dried brown drainage was on the bedsheet and fitted sheet under the pillows. NA-A removed the gloves and put on new ones. NA-A took off R25's pants by lifting his legs and maneuvered the foley catheter tubing and drainage bag through the pant leg and washed R25's face, armpits and peri-area with a washcloth. NA-B put on gloves and was on the opposite side of R25's bed. NA-B assisted with turning R25 onto his side by putting his hands on R25's side. NA-A was leaning on the edge of the bed and washed R25's backside with a washcloth. There was a small amount of a bowel movement cleaned up on the washcloth and on the incontinence pad. There was a foam dressing covering a wound on the sacral area, with the wound dressing edges peeling off. NA-A	F 880	audits for 2 weeks, and then will be weekly for 2 weeks to ensure or until substantial compliance met for compliance of PPE and transmission. DON or designee will be responsible Compliance Date 6/3/22	

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F 880	Continued From page 77	F 880		

removed R25's soiled incontinence brief and put it in the garbage. At 7:09 p.m. licensed practical nurse (LPN)-A entered R25's room. LPN-A had on gown and gloves, along with eye protection and face mask. LPN-A immediately told NA-A and NA-B they needed to have gowns on during direct care. LPN-A noted the sheets which were soiled with drainage from foot wounds. NA-A washed his hands and left the room shortly thereafter. NA-B remained in the room until 7:14 p.m.

During an interview on 5/2/22, at 7:09 p.m. NA-A reviewed the contact precautions sign posted on the outside of R25's room which indicated to wear gown when it was anticipated that clothing would touch patient items or potentially contaminated environmental surfaces. NA-A stated he did not think he needed to wear a gown unless he was dealing with urine or wounds. NA-A agreed however that the sheets and pad were potentially contaminated environmental surfaces. NA-A also acknowledged there was no shortage of PPE or gowns provided by the facility.

During an interview on 5/2/22, at 7:14 p.m. NA-B stated he saw the PPE bin and sign on the door before he went in to provide cares but did not read it.

During an interview on 5/2/22, at 8:02 p.m. the infection preventionist (IP) stated gowns needed to be worn for direct care for R25 and when a resident was on contact precautions.

During an interview on 5/5/22, at 3:22 p.m. the director of nursing (DON) stated staff are expected to follow TBP for contact precautions and gowns should be worn to help prevent the spread of infection.

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Facility policy, Isolation - Categories of TBP, undated, directed staff to wear a disposable gown upon entering the contact precautions room. After the gown was removed do not allow clothing to potentially contaminate environmental surfaces.

The CDC article "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" dated 2/2/22, indicated staff working in facilities located in counties with a high transmission rate, regardless of their vaccination status, should utilize source control such as a well-fitting facemask and wear eye protection such as goggles or a face shield covering the front and sides of the face, during all resident encounters.

The CDC COVID Data Tracker indicated the Goodhue County community transmission rate was listed as "high" from 4/28/22 to 5/5/22.

R3's quarterly Minimum Data Set (MDS) dated 4/18/22, indicated R3 had intact cognition and had diagnoses of chronic heart failure, anemia, paraplegia (paralysis to lower extremities), seizures, malnutrition, respiratory failure, and asthma.

During an observation upon initial entry to the facility on 5/2/22, at 12:58 p.m. housekeeper (HK)-A was mopping the floor in the main resident dining room without eye protection and cook (CK)-B was cleaning in the main kitchen after lunch service without eye protection or a mask.

During an observation and interview on 5/2/22, at 1:07 p.m. dietary director (DD) stated staff should

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wear a mask at all times while in the facility. The DD then advised CK-B to put a mask on. During interview, CK-C was also observed without eye protection or a mask on. The DD then advised CK-C to also put a mask on. The DD further stated staff have not been required to wear eye protection since the last time a resident tested positive for Covid-19, around January, 2022.

During an interview on 5/2/22, at 1:13 p.m. HK-A stated the facility had not been enforcing the use of eye protection for a few months and HK-A did not know what the facility's policy was for wearing eye protection.

During an observation on 5/2/22, at 1:23 p.m. nursing assistant (NA)-G walked down the unit hallway without eye protection, next to R3 who was in his electric wheelchair without a mask on. NA-G and R3 went into R3's room and closed the door behind them. Approximately one minute later NA-G, without eye protection, and R3, without a mask, exited R3's room and proceeded down the hallway towards the front entrance of the facility next to each other.

During an interview on 5/2/22, at 2:46 p.m. NA-G stated the nurses or leadership team would advise the staff if they needed to wear eye protection, but the staff had not been told to wear eye protection for "a few months" because there was no resident with Covid-19 in the facility.

During an interview on 5/2/22, at 5:23 p.m. the infection preventionist (IP) stated staff were to be wearing eye protection whenever they were in a resident care area or other area where residents were present, including hallways and dining rooms, to avoid possible exposure to illness. The

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IP also stated all staff should be wearing masks while in the facility, including the kitchen staff. The IP further stated staff compliance with wearing proper PPE was an ongoing issue.

Review of the facility infection surveillance tracking log indicated no resident facility or community aquired infections had been tracked or analyzed for trends since February 2022.

During an interview on 5/4/22, at 12:34 p.m. the director of nursing (DON) stated the facility's policies and procedures were provided by the company that owned the facility over a year ago and did not have dates to indicated if they had been reviewed or revised annually. The DON also stated the facility relied on the previous owner's policy and procedure database but no longer had access and therefore, could not provide any policies other than what they currently may have. The DON further stated the IP was not available for interview but emailed her surveillance logs to the DON. The DON verified the surveillance logs lacked any data since February 2022 although residents had had active infections since then.

The facility Personal Protective Equipment-Using Protective Eyewear policy, undated, indicated personal eyeglasses were not considered to be adequate protective eyewear. Protective eyewear must also have adequate side and top coverage and fit the employee properly. Eyewear was to be worn to protect employees' eyes from potentially infection material. The policy did not indicate the use of eyewear according to the CDC guidelines or to help prevent the spread of the COVID-19 virus during the pandemic.

The facility Protective Equipment-Using Face

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F 880	Continued From page 81 Masks policy, undated, indicated face masks were to be used when providing treatment or services to a resident when the use of a mask was indicated. The policy did not reference the COVID-19 pandemic or the CDC guidelines for use of face masks during the COVID-19 pandemic. The facility Health Care Worker Mandatory Vaccination Policy, undated, indicated staff were considered to be fully vaccinated two weeks after receiving the requisite number of doses of a COVID-19 vaccine. The policy lacked reference to the CDC and CMS requirement that staff receive all recommended doses of COVID-19 vaccines including any booster dose(s) when eligible to be considered "up-to-date". The policy also lacked procedures for staff who were not up-to-date with their COVID-19 vaccines including required routine testing. The facility Infection Control policy and procedure undated, indicated the IP shall keep abreast of changed in infection prevention and control guidelines and regulations to ensure facility protocols remain current. The IP shall collect, and report statistics related to facility infections, trends, patterns and issues.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program	F 881		6/3/22

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F 881	Continued From page 82 that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive antibiotic stewardship program, with established monitoring, to help reduce unnecessary antibiotic use, reduce potential drug resistance, and help prevent the spread of infectious diseases. The lack of a program had potential to affect all 31 residents residing in the facility. Findings include: Review of the facility infection surveillance tracking log indicated no resident infections or antibiotic use had been tracked or analyzed since February 2022. During an interview on 5/4/22, at 12:34 p.m. the director of nursing (DON) stated the IP was not available for interview but had emailed her surveillance logs to the DON. The DON verified the surveillance logs lacked any data since February 2022 although residents had had active infections since then. The facility Antibiotic Stewardship Policy dated 9/2017, indicated the facility would monitor antibiotic use and outcome(s) from antibiotic use and resistance, and provide regular feedback to prescribing clinicians, nursing staff, and other relevant staff. The IP would complete monthly chart reviews of all ordered and administered antimicrobials, record the data and present it for review of trends to the Quarterly Quality Assurance Committeen Meeting.	F 881	F881 Antibiotic Stewardship. Facility must establish an IP program (IPCP) must include: An antibiotic stewardship program that includes antibiotic use, protocols and a system to monitor antibiotic use. The facility failed to develop and implement a comprehensive antibiotic stewardship to reduce unnecessary antibiotic use. Facility antibiotic stewardship program dated 9/2017 indicated the facility would monitor antibiotic use outcomes from antibiotic use and resistance, provide regular feedback to prescribing clinicians, nursing staff and other relevant staff. IP would complete monthly chart reviews of all ordered administered antimicrobials, record date and bring to QAPI. Review of the facility infection surveillance tracking log indicated no resident or infections or antibiotic use had been tracked or analyzed since February 2022. Resident surveillance data will be submitted and reviewed by QAPI. Biweekly for 2 months, the IP will submit the surveillance spreadsheet to the DON and administrator for review to ensure compliance until substantial compliance is met. DON or designee will be responsible .	

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F 881	Continued From page 83	F 881	Compliance date of 6/3/22	
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing:	F 886		6/3/22

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F 886	Continued From page 84 (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure routine COVID-19 testing occurred for 54 staff members who were not up-to-date with their COVID-19 vaccinations according to the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all 38 residents, staff and visitors in the facility. Findings include:	F 886	F886 Covid testing residents and staff in long term care must test residents and facility staff including individuals providing services under arrangements and volunteers for Covid. At a minimum for all residents and staff including indivdual providing services under arrangements. This can affect all residents and staff. Facility failed to ensure routine covid testing occurred for staff members whom were not fully vaccinated against Covid	

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F 886	Continued From page 85 The CDC "Interim Infection Prevention and Control Recommendation to Prevent SARS-CoV-2 Spread in Nursing Homes" dated 2/2/22, indicated nursing homes located in counties with substantial to high community transmission rates should test non "up-to-date" staff twice a week. With the CDC defining up-to-date with vaccinations as having received all vaccination doses in the primary series and one booster when eligible. Additionally the recommendation for staff who worked infrequently at the facility were to be tested ideally, three days prior to their shift (including the day of their shift). The CDC COVID Data Tracker indicated the Goodhue County community transmission rate was listed as high from 4/28/22 to 5/5/22. Review of the facility staff vaccination records, untitled, dated 5/3/21, indicated out of 79 staff, two were partially vaccinated, one had a medical exemption, three had religious exemptions, four were not eligible for a booster based on the date of their previous COVID-19 shot, and 44 who were eligible, had not received their booster dose. This totalled 54 staff were not vaccinated or not up-to-date with their vaccines and were required to be tested for COVID-19 twice a week according to the CDC and CMS guidelines. During an interview on 5/2/22, at 5:23 p.m. the infection preventionist (IP) stated the previous administrator would inform her what the community transmission rate was to determine the facility guidelines for staff testing, however, since the new administrator started in January 2022, she had not received that information and did not know how to find it on the CDC website.	F 886	19. Facility failed to ensure routine Covid testing occurred for staff members who were not up to date with their Covid vaccines. The staff roster will be reviewed to evaluate what staff members will need biweekly testing or testing according to county transmission rates. The IP will monitor the transition rate of the county. IP will submit test results to DON or designee twice weekly for one month, or until substantial compliance is met. Results will be discussed at QAPI. DON or designee will be responsible Compliance date 6/3/22	

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F 886	Continued From page 86 The IP also stated only two staff members, who both worked intermittently, were unvaccinated and were tested prior to working a shift; however, the IP was unable to provide records of the employees' COVID-19 tests or the results. The IP also stated staff who had not received their COVID-19 booster were not tested twice a week, according to the CMS or CDC guidelines, because she was unaware of the requirement. During an interview on 5/4/22, at 12:34 p.m. the director of nursing (DON) verified staff who were unvaccinated or not up-to-date with their COVID-19 vaccinations had not been tested according to the CMS or CDC guidelines of twice a week and the staff who worked part-time or intermittent were not tested prior to their shift working. During an interview on 5/4/22, at 10:12 a.m. the administrator stated he believed the community transmission level was "low" and had stated he had referenced the incorrect COVID-19 community level instead of the correct community transmission level which labeled Goodhue County, the county of residence for the facility, as having a community tranmission level of high. A facility policy for testing staff who were not up-to-date with their COVID-19 vaccines including booster dose(s) when eligible was requested but not provided.	F 886		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 921		6/3/22

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F 921	Continued From page 87 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview for environmental concerns, the facility failed to ensure 15 of 15 chairs located in the dining room were in good repair and cleanable and this had the potential to affect all facility residents who used the dining room. Findings include: During observation on 5/4/22, at 7:31 a.m. it was found all of the dining room chairs had damage to the seat cushions. The vinyl surface had peeled off exposing the fabric below. The degree of damage on each chair cushion varied from 25 to 50 percent of the vinyl peeled off. The edges between the vinyl and fabric were peeling upward, leaving an uneven surface. During the cleaning process the peeled areas would move back and forth creating a space for debris and bacterial growth. Each chair had various sized dark stains on the exposed fabric. During interview on 5/4/22, at 7:51 a.m. R24 stated she eats all of her meals in the dining room. R24 stated all of the chair cushions were in disrepair. R24 stated, "I have better chairs at home" and she wanted the facility to re-upolster the chairs. During observation and interview on 5/4/22, at 8:01 a.m. R22 stated, she sits on the dining room chairs for all of her meals. R22 stated she did not like the condition of the chair cushions. During interview on 5/4/22, at 11:17 a.m. housekeeping (H)-A stated the dining room chairs	F 921	F921 Safe, functional, Sanitary comfortable environment. The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview for environmental concerns, the facility failed to ensure 15 of 15 chairs located in the dining room were in good repair and cleanable and this had the potential to affect all facility residents who used the dining room. During observation on 5/4/22, at 7:31 a.m. it was found all of the dining room chairs had damage to the seat cushions. The vinyl surface had peeled off exposing the fabric below. The degree of damage on each chair cushion varied from 25 to 50 percent of the vinyl peeled off. The edges between the vinyl and fabric were peeling upward, leaving an uneven surface. During the cleaning process the peeled areas would move back and forth creating a space for debris and bacterial growth. Each chair had various sized dark stains on the exposed fabric. All Residents can potentially be affected. New chairs will be added to the capital budget. The environmental director will add it to the bi-annual inspection to	

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F 921	Continued From page 88 looked bad. H-A stated she used Ecolab Peroxide Multi-Surface Cleaner and Disinfectant product to clean the chairs. During interview on 5/4/22, at 12:28 p.m. cook (C)-A stated after each meal it was the dietary aides responsibility to clean the dining room chairs. C-A added they use Ecolab Sink and Surface Cleaner, or Ecolab Peroxide Multi-Surface Cleaner and Disinfectant to clean the chairs. During interview on 5/5/22, at 11:02 a.m. Ecolab sales representative (R)-C stated Peroxide Multi-Surface Cleaner and Disinfectant was intended to clean only hard surfaces. R-C stated the product is only effective when a hard surface is saturated for 15 seconds before wiping it off. R-C did not recommend this product on fabric because it would be difficult to effectively saturate and wipe off. R-C stated this product was not designed to clean and remove body fluids from a fabric surface. R-C added when fabric is soiled it would need a product designed for cleaning clothes, towels, and linen. During interview on 5/5/22, at 11:50 a.m. administrator stated the chairs looked bad but with the new ownership and financial concerns, the focus was more on providing the tools necessary to care for the residents rather instead of fixing furniture. Administrator stated the condition of the chairs could lead to a potential infection control issue. Administrator also stated after learning the cleaning products currently being used were ineffective on fabric, he would look for a solution to cover the exposed fabric. The facility policy Cleaning and Disinfection of	F 921	determine whether the chairs need to be fixed or replaced. The Environmental Director or designee will be responsible. Compliance date	

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F 921	Continued From page 89 Environmental Surfaces not dated, indicated the facility would follow manufacture's guidelines for proper disinfection or detergent use depending upon the type of surface or material.	F 921		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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THE TERRACE AT CANNON FALLS	300 NORTH DOW STREET CANNON FALLS, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately documented and recorded regarding antidepressant medication use for 1 of 5 residents (R31) reviewed during unnecessary medication use. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2019, identified the RAI was used to help ensure staff reviewed the resident holistically to help provide quality care and quality of life. The manual reviewed each section of the RAI including, "Section N: Medications." This directed to record the number of days any type of the selected medication was received by the resident during the review period. Further, the manual directed, "Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is used." R31's admission MDS, dated 4/8/22, identified, under section N0410, R31 received antipsychotic medication during the review period. The classification of antidepressant was left unchecked. However, R31's Physician Orders, dated 4/4/22, indicated sertraline (antidepressant) tablet 50 milligrams, give one tablet by mouth in the morning related to major depressive disorder. During an interview on 5/4/22, at 9:06 a.m. registered nurse (RN)-A verified she submitted R31's MDS, dated 4/8/22, including section N (Medications). RN-A reviewed section N and the physician's orders and stated antipsychotic was coded and should not have been. RN-A stated the antidepressant sertraline was not coded and should have been. RN-A stated accurate coding was important for billing and care planning purposes. During an interview on 5/5/22, at 1:34 p.m. the director of nursing (DON) stated the MDS coding should be accurate. The facility policy Resident Assessment Instrument, undated, identified the MDS must be signed attesting to its accuracy.

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/05/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/05/2022. At the time of this survey, THE TERRACES was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/05/2022

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

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/05/2022**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. THE TERRACES is a 1 story building. The building was constructed at four different times. The original building was built in 1977 and was determined to be of Type II (111) construction. In 1982 an addition was constructed to the West Wing and was determined to be of Type II (111) construction. In 1985 an addition was constructed to the South Wing and determined to be of Type III (111)	K 000		

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K 000	Continued From page 2 construction. In 2007 the Chapel was added to the structure and was determined to be of Type V (000), having a 2 hour separation from the main building. 2 hour building separation between Nursing home Type II and Chapel Type V building. Because the original building and the additions are of the same type of construction allowed for existing buildings, the facility was surveyed has one building - Type II (111). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 24 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 211	K211	6/3/22

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K 211	Continued From page 3 facility failed to maintain a continuously unobstructed means and path of egress per NFPA 101 (2012 edition), Life Safety Code, section19.2, 7.1.10. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that in the S Corridor that clear access to the exit door at the end of the corridor was obstructed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	1. The obstruction in the corridor was cleared 05/05/22. Staff were reeducated on 05/05/22 that objects are not to be placed in the hallways in a manner that will obstruct Means of Egress and access to Fire Extinguishers by Director of Environmental Services. Continuing education will be provided at future in-services. In addition to on-the-spot education if the practice is found on daily rounds by the Environmental Director 2. Director of Environmental Services is doing daily round of the building to ensure no objects are being stored in the halls unnecessarily and/or in a manner that restricts fire safety devices. If such objects are found Director of Environmental Services will move the object and reeducate staff. 3. Staff will continue to be reeducated and randomly quizzed on proper placement of items in the halls on daily rounds of the building by Director of Environmental Services. 4. Director of Environmental Services and Maintenance Assistant will both do rounds of the building multiple times a day and ensure the halls stay free of obstructions. The quality assurance committee will do monthly building audits to ensure the halls stay free of obstruction. 5. Completion date of 06/03/22	
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7,	K 271		6/3/22

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K 271	Continued From page 4 provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and properly maintain points of exit in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2, 7.1.7, 7.7. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that the egress to grade outside of the 200 Wing exit door, had a vertical displacement greater than one-half inch and a horizontal displacement greater than one-half inch, presenting a fall and trip hazard 2. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that the egress to grade outside of the Dining Room exit door, had a vertical displacement greater than one-half inch, presenting a fall and trip hazard 3. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that the egress to grade outside of the Chapel Corridor exit door, had a horizontal displacement greater than one-half inch around the entire concrete slab, presenting a fall and trip hazard An interview with the Maintenance Director	K 271	K271 1. The egress to grade on the 200 Wing Door, Dining Room Door, and Chapel Door will all be corrected by installing a spacer from egress to grade to cover the gap(s) and slope to grade. Parts have been ordered and are on back order. 2. Director of Environmental Services will do monthly inspections of the egress to grade. If doors develop a displacement of greater than one-half inch additional spacers will be installed. 3. Director of Environmental Services will do monthly inspections of the egress to grade. 4. The quality assurance committee will do annual building audits to ensure egress to grade is no more than one-half inch. 5. Completion date of 6/03/22	

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K 271	Continued From page 5 verified these deficient findings at the time of discovery.	K 271		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly identify points of exit in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10 This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that points of exit in the facility, so identified with ceiling mounted illuminated signs, had conflicting signage mounted on the door - incorrectly identifying the door as "not" a point of exit or egress. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 293	K293 1. The signage on all Exit doors was changed 05/05/22 and now reads Emergency Exit Only, Alarm Will Sound. 2. The Director of Environmental Services has checked all signage in the building to ensure it is written correctly. New signage will be doubles checked for accuracy before being used in the building. 3. The Director of Environmental Services will ensure that only proper signage is used on all the building doors. 4. The quality assurance committee will do bi-annual building audits to ensure proper signage is used on all the building doors. 5. Completion date of 05/05/22	6/3/22
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		6/3/22

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K 345	Continued From page 6 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and staff interview, the facility failed to inspect and maintain initiating devices of fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4 and 9.6.2, and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 14.1.1 and 14.2.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed during documentation review that the fire alarm system servicing vendor had noted defects and malfunctions found in the course of serving the system. No supporting documentation was provided or available for review to confirm the noted defects and malfunctions had been repaired 2. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that there was obstructed access to manual fire alarm pull-stations in the following locations: Lobby Area of the facility and in the S Corridor adjacent to the exit door.	K 345	K345 1. The fire alarm servicing vendor was contacted and requested for service to repair the noted malfunction on 05/05/22. The obstructed access to the fire alarm pull station was cleared by relocation the furniture on 05/05/22. 2. Problems found on inspections of the fire alarm system will be schedule for repair on the same day notice of the problem is received to Director of Environmental Services. Director of Environmental Services and Maintenance Assistant will round daily and ensure the fire alarm pull stations and other related fire safety devices stay free of obstructions. 3. Records will be kept of repair work to the fire alarm system to ensure the work has been completed. Director of Environmental Services and Maintenance Assistant will both do rounds of the building multiple times a day and ensure the fire alarm pull stations stay free of obstructions. 4. Monthly review of completed annual documentation will be completed by the Director of Environmental Service to	

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K 345	Continued From page 7 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	ensure no needed repairs get missed. Director of Environmental Services and Maintenance Assistant will both do rounds of the building multiple times a day and ensure the fire alarm pull stations stay free of obstructions. 5. Completion date of 05/17/22 for the alarm system repair. Completion date of 05/05/22 for the obstructed pull station	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and staff interview, the facility failed to inspect and maintain initiating devices of fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that the facility has an out-of-service policy associated	K 346	K346 1. A new fire alarm out of service policy has been added to the facility emergency preparedness plan to ensure a fire watch is started if the building fire alarm system is down for more than four hours. The fire watch will use the form already in use for the sprinkler system out of service. 2. The full emergency preparedness plan has been rewritten to ensure all fire safety deficiencies have been eradicated. 3. The building emergency preparedness plan will be reviewed quarterly by the Director of Environmental Services to ensure it remains up to date	6/3/22

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K 346	Continued From page 8 to the fire alarm system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	and is not missing anything. 4. The quality assurance committee will review the emergency preparedness plan annually to ensure it remains up to date and is not missing anything. 5. Completion date of 06/3/22	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5.2(3),4.1.6, 5.1, 5.2.	K 353	K353 1. All damaged and missing ceiling tiles were replaced 05/05/22. Maintenance Assistant was reeducated 05/05/22 to not remove ceiling tiles unless replacing them. The Director of Environmental Services is locating all leaks in the roof and repairing them, this will be an ongoing	6/3/22

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K 353	Continued From page 9 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that ceiling tiles were either damaged or missing in the following location in the facility: RM 104, S Nurses Station, Social Services Office, Physical Therapy Area, RM 430, RM 448, 300 Wing Corridor, 200 Wing Corridor, Kitchen Janitor Closet, Director of Nursing Office. The absence of ceiling tiles in these areas could affect the overall operation and effectiveness of the facility sprinkler system. 2. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that in the Kitchen and Dishwashing Area that sprinkler heads exhibited signs of oxidation as-well-as being covered with a foreign substance 3. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that in the Social Services storage closet that items were stored and stacked within less-than 18 inches of the sprinkler head An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	process. The sprinkler servicing vendor was contacted to replace all 14 sprinkler heads for the kitchen, dish room, storage, and office with the white nonoxidizing sprinkler heads on 05/05/22, and work was completed 05/27/22. The items in the social workers closet were moved to ensure nothing is within 18 inches of the sprinkler heads. Staff has been educated that nothing may be stored within 18 inches of sprinkler heads. 2. The Director of Environmental Services will reverify all fire safety functions are clean and not obstructed as well as ensure all ceiling tiles remain in place. 3. The Director of Environmental Services will do weekly rounds to ensure all ceiling tiles are in place and intact. The Director of Environmental Services will ensure all sprinkler heads that get oxidized are replaced and dirty heads are cleaned or replaced. The Director of Environmental Services will do daily rounds and continue to reeducate staff to ensure nothing is stored within 18 inches of sprinkler heads. 4. The quality assurance committee will do bi-annual building audits to ensure all ceiling tiles remain in place and intact, sprinkler heads are clean and free of oxidization, and free from obstruction. 5. Completion date of 05/05/22 for the ceiling tiles, completion date of 05/27/22 for the sprinkler head replacement, completion date of 05/05/22 for the sprinkler head obstruction.	
K 355 SS=F	Portable Fire Extinguishers	K 355		6/3/22

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

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K 355	Continued From page 10 CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain documentation records associated to portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3, . This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed during documentation review that no vendor inspection records were presented to confirm the annual inspection and if any extinguishers required corrective action 2. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed during documentation review that no in-house inspection records were presented to confirm the monthly inspections of all facility fire extinguishers were being completed 3. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that the fire extinguisher in the area of the S Corridor exit was access obstructed.	K 355	K355 1. Vendor inspection records will be kept by Director of Environmental Services on all fire extinguisher servicing and inspection. A monthly log will be created by Director of Environmental Services to track monthly inspection of all fire extinguishers. Staff were reeducated on 05/05/22 that objects are not to be placed in the hallways in a manner that will obstruct fire extinguishers. 2. All fire safety features will continue to be checked monthly to ensure all documentation is kept. Director of Environmental Services and Maintenance Assistant will both do rounds of the building multiple times a day and ensure no objects are placed within 3 feet of fire safety features. 3. Staff will continue to be reeducated and randomly quizzed on proper placement of items in the halls on daily rounds of the building by Director of Environmental Services. 4. Director of Environmental Services and Maintenance Assistant will both do rounds of the building multiple times a day and ensure the halls stay free of obstructions. The quality assurance	

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K 355	Continued From page 11 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	committee will do monthly building audits to ensure the halls stay free of obstruction. 5. Completion date of 05/05/22	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain, test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed during the walk-thru of the facility that upon testing of the smoke barrier doors, in the area of the Nurses Station, it did not	K 374	K374 1. Closing hardware one the malfunctioning door will be replaced. Parts on backorder. Properly functioning closing hardware will be in place to ensure the door closes completely by itself. 2. All self-closing doors will continue to be inspected monthly. Closing hardware requiring adjustment two months in a row will be replaced. 3. The closing hardware on this door will be replaced when the parts arrive. New hardware will be adjusted to ensure the door functions properly every time.	6/3/22

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K 374	Continued From page 12 self-close to resist the passage of smoke An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 374	Checks of the doors will be done on a monthly basis. 4. The director of Environmental Services will ensure old hardware is replaced with newer more reliable hardware as it begins to fail. 5. Completion date of 06/3/22	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper security of electrical panels in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26, and NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/05/2022 between 8:15 AM to 12:15 PM, it	K 511	K511 1. All electrical panels were locked 05/05/22 after inspection. 2. Director of Environmental Services will check everything that is required to be locked on Daily rounds. 3. Director of Environmental Services will check all panel locks monthly. 4. The quality assurance committee will do bi-annual building audits to ensure all electrical panels remain locked 5. Completion date of 05/05/22	6/3/22

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K 511	Continued From page 13 was revealed by observation that electrical panels in a resident accessible corridor were found unsecured in the following locations: S Nurses Station and adjacent to resident RM 415 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based a review of available documentation the facility failed to conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.2, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed during documentation review that documentation presented for review identified that fire drills were not conducted during: 1ST	K 712	K712 1. Fire drills will be conducted each quarter with one shift per month. Fire drills will no longer be all done in the last week of the month. 2. Director of Environmental Services will ensure fire drills are less predictable. 3. Director of Environmental Services will look at the fire drill date of the previous months before completing a fire drill to ensure weeks are not being repetitive. 4. Director of Environmental Services	6/3/22

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K 712	Continued From page 14 SHIFT in the 2ND and 3RD quarters; 2ND SHIFT in the 2ND and 3RD quarters; and 3RD SHIFT in the 3RD quarter 2. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed during documentation review that documentation presented for review identified a pattern of when fire drills were conducted, all drills were conducted in the last week of the months An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 712	will review the logbook monthly to ensure fire drills are being conducted correctly. 5. Completion date of 06/03/22	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.	K 914		6/3/22

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K 914	Continued From page 15 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain electrical receptacles in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4.1.4, 6.3.4.2.1.2 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by a review of available documentation that documentation presented for review did not individually identify the results of the multi-point inspection for each of the individual outlets located in resident rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	K914 1. Each individual outlet will be identified separately on annual outlet inspections moving forward. 2. All new documentation will be reviewed to ensure everything is as detailed as it can be. 3. Documentation templates on the computer will be changed to show the requirement of individual identification of electrical outlets. 4. Director of Environmental Services will review the logbook monthly to ensure logbook is completed to meet the requirements of NFPA 99 5. Completion date of 05/05/22	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		6/3/22

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K 920	Continued From page 16 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of electrical adaptive devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have an isolated impact on the residents within the facility. Findings include: 1. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed during facility walk-thru of the facility that in the Admin Office a high amperage appliance was connected to a power-strip 2. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed during facility walk-thru of the facility that in the Kitchen Office that power-strips were daisy-chained An interview with the Maintenance Director verified these deficient findings at the time of	K 920	K920 1. High amperage appliance was removed from power strip and plugged into the wall in Administrators Office 05/05/22. Daisy-chained power strip was removed from Kitchen Office 05/05/22. 2. Director of Environmental Services will add Offices to the monthly rounds of the building when looking for electrical violations. 3. Director of Environmental Services will add Offices to the monthly rounds of the building when looking for electrical violations. 4. Director of Environmental Services will review documentation to ensure Offices are checked when completing monthly rounds for electrical violations. 5. Completion date of 05/05/22	

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K 920	Continued From page 17 discovery.	K 920		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored	K 923		6/3/22

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K 923	Continued From page 18 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 5.1.3.3.2(2), 5.1.3.3.4, 5.1.3.3.4.1, 11.3, 11.3.2, 11.3.2.3, 11.3.4, 11.6.2, 11.6.2.3(3), 11.6.5, NFPA 55 (2010 edition), Compressed Gases and Cryogenic Fluids Code, sections 7.1.4.2.1, 7.1.8.4, 7.1.8.1, 7.1.8.2, This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation in the Med Gas Storage and Transfill Room that there exhaust fans was not functioning properly 2. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that in the Med Gas Storage and Transfill Room there was a free-standing e-cylinder and no rack for storage 3. On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by observation that in the Med Gas Storage and Transfill Room that there was no signage to identify "empty" and "full" cylinder placement locations An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 923	K923 1. Exhaust fan in Med Gas Room has been repaired 06/02/22. E-cylinders will be stored in an appropriate manor and will not be free standing. Signage will be placed on wall of Med Gas Room to indicate the placement of Empty and Full Cylinders 2. Director of Environmental Services will ensure proper signage is used in storage rooms and items are stored correctly with functional ventilation where required. 3. Director of Environmental Services will check the Med Gas Room for correct storage usage weekly and educate staff when errors are made. 4. The quality assurance committee will do bi-annual building audits to ensure the Med Gas Room has everything stored appropriately. 5. Completion date of 06/03/22.	
K 926 SS=F	Gas Equipment - Qualifications and Training	K 926		6/3/22

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K 926	Continued From page 19 CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation the facility failed to confirm that a medical gas training program is in use per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2. This deficient finding widespread impact on the residents within the facility. Findings include: On 05/05/2022 between 8:15 AM to 12:15 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that a medical gas training program is currently in use by the facility. An interview with Director of Nursing verified this deficient finding at the time of discovery.	K 926	K926 1. Med Gas Training Power Point and Competency Test material has been obtained from Northwest Respiratory. Training will be provided to staff and staff will complete competency testing. Documentation will be kept for all clinical staff. 2. All training required by The Terrace at Cannon Falls will be reviewed to ensure that minimum state requirements are met or exceeded. 3. The Terrace at Cannon Falls will be continually reviewing all training required to ensure that minimum state requirements are met or exceeded. 4. The quality assurance committee will do annual building audits to ensure all required training has been completed. 5. Completion date of 06/03/22	