Electronically Delivered

August 18, 2022

Administrator
Cannon Country
308 Larkspur Lane
Cannon Falls, MN 55009

RE: Project Number(s) SL37873015

Dear Administrator:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial evaluation on June 14, 2022, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91 Subd. 8), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Paul Spencer, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: paul.spencer@state.mn.us
Phone: 651-587-4460 | Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37873	A. BUILDING: _____ B. WING _____	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON COUNTRY	308 LARKSPUR LANE 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) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#37939015 On June 13, 2022, through June 14, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were three residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 13, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a comprehensive tuberculosis (TB) infection control prevention program according to the most current guidelines issued by the Centers for Disease Control (CDC), including a (TB) facility risk assessment, a baseline TB screening and testing for the presence of the infection with a two-step tuberculin skin test (TST) or single TB blood test, and provide staff education for six of six employees (Chief Executive Officer (CEO)-A, Housing Manager (HM)-B, Register nurse (RN)-C, Assistant Manager (AM)-D and	0 660		

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0 660	Continued From page 3 unlicensed personnel (ULP)-E, ULP-F) with records reviewed. This had the potential to affect all three residents receiving assisted living services, as well as staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: FACILITY TB RISK ASSESSMENT The CDC guidelines indicate a facility risk assessment should be performed on an annual basis to ensure infection control measures match the facilities risk level. The guidelines also indicate the level of infection control measures employed by the facility should match the risk classification for the setting. During an interview on June 13, 2022, at approximately 11:15 a.m., the CEO-A stated he believed the licensee had a completed facility TB risk assessment but was unable to indicate the licensee's facility risk level. During a phone interview on June 13, 2022, at 12:26 p.m., the HM-B stated the licensee did not have a completed facility TB risk assessment. EMPLOYEE SCREENING AND EMPLOYEE TB TESTING RESULTS CEO-A	0 660		

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0 660	Continued From page 4 CEO-A was hired on November 15, 2021. CEO-A's employee record lacked evidence of an assessment for TB history, a baseline test (with either TST 2-step or a blood assay for M. tuberculosis (BAMT), and TB education. HM-B HN-B was hired on November 15, 2021. HM-B's employee record lacked evidence of an assessment for TB history, a complete baseline test (with either TST 2-step or a blood assay for M. tuberculosis (BAMT), and TB education. RN-C RN-C was hired on August 1, 2021. RN-C's employee record lacked evidence of an assessment for TB history, a baseline test (with either TST 2-step or a blood assay for M. tuberculosis (BAMT), and TB education. AM-D AM-D was hired on January 2, 2022. AM-D's employee record employee record lacked evidence of an assessment for TB history, a complete baseline test (with either TST 2-step or a blood assay for M. tuberculosis (BAMT), and TB education. ULP-E ULP-E was hired on March 10, 2022. ULP-E's employee record lacked evidence of an assessment for TB history and TB education. ULP-F ULP-F was hired on August 20, 2021.	0 660		

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0 660	Continued From page 5 ULP-F's employee record lacked evidence of an assessment for TB history and a baseline test (with either TST 2-step or a blood assay for M. tuberculosis (BAMT). During an interview on June 14, 2022, at 11:25 p.m., CEO-A handed the employee records to AM-D and AM-D verified each employee record was missing the above identified information. The licensee provided Tuberculosis & Staff Screening Policy, dated August 1, 2021, indicated the licensee will observe the recommended precautions related to TB prevention as identified by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). The precautions include the following elements: Risk Assessment, TB screening, staff education. The policy indicated the director is responsible for conducting the formal TB Risk Assessment and updating it annually. The policy further indicated employees receive baseline TB screening with an assessment for TB history and current TB symptoms and a baseline test with either TST 2-step or a blood assay for M. tuberculosis (BAMT). TIME PERIOD FOR CORRECTION: Seven (7) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 6 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms in the facility and ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).	0 780		

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0 780	Continued From page 7 The findings include: On 06/14/2022 at approximately 11:00 AM, survey staff observed facility smoke alarms located in bedrooms could not be assessed for month/year of install or manufacture date. On 06/14/2022 at approximately 11:00 AM, survey staff observed that the smoke alarms located just outside of each bedroom were not interconnected to those in the bedrooms. CEO-A verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect	0 800		

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0 800	Continued From page 8 all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). Findings include: On 06/14/2022 at approximately 11:00 AM, survey staff observed improper use of power strips in the facility's mechanical room. On 06/14/2022 at approximately 11:00 AM, survey staff observed combustible items being stored less-than 3 feet from a fuel-fired appliance (furnace). On 06/14/2022 at approximately 11:00 AM, survey staff observed bedroom egress windows were visually and physically obstructed. CEO-A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 9 rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 10 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). Findings include: On 06/14/2022 at approximately 11:00 AM, survey review of documentation showed the following: 1. No records were provided to confirm that the staff of the facility had received initial fire safety and evacuation training at the time of hire, as well as ongoing required twice per year thereafter. 2. No records were provided to confirm that residents capable of assisting in their own evacuation are being trained on proper actions at least annually. 3. No records were provided to confirm that evacuation drills are being conducted twice per year per shift with at least one drill every other month CEO-A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01460 SS=E	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to	01460		

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01460	Continued From page 11 residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure four of six employees (Chief Executive Officer (CEO)-A, Housing Manager (HM)-B, registered nurse (RN)-C, unlicensed personnel (ULP)-E) received orientation to assisted living facility licensing requirements and regulations with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CEO-A CEO-A was hired on November 15, 2021. HM-B HM-B was hired on November 15, 2021. RN-C RN-C was hired on August 1, 2021. ULP-E ULP-E was hired on March 10, 2022.	01460		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01460	Continued From page 12 CEO-A, HM-B, RN-C, and ULP-E's records did not include evidence the employees received orientation to include the following topics prior to providing assisted living services: - an overview of this chapter [144G] - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. - handling of emergencies and use of emergency services. - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure During an interview on June 14, 2022, at 11:25 a.m., CEO-A stated the employee records provided to surveyors was what the licensee had for employee record content. The licensee provided Staff Orientation and Education policy dated August 1, 2021, indicated	01460		

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01460	Continued From page 13 orientation topics will include: -an overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659 -review of the employee's job description and responsibilities -introduction to and review of the organization's policies and procedures related to the provision of assisted living services by the individual staff person -handling of emergencies and the use of emergency services -compliance with Minnesota's Vulnerable Adult (Sections 626.556 and 5572), including requirements based on organization policy, identification of incidents of maltreatment (abuse, financial exploitation, and neglect) and that ay act that constitutes maltreatment is prohibited -the Assisted Living Bill of Rights and the employee's responsibilities to ensure the exercise and protection of those rights -the principles of person-centered planning and service delivery and how they apply to direct support services provided by staff -grievance policy/process, including reports to the office of Health Facility Complaints -consumer advocacy services: Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, County managed care advocates, other advocacy services -the types of assisted living services the employee will be providing based on the Uniform Checklist Disclosure of Services and the organization's category of licensure -the organizational chart and roles of staff within the facility TIME PERIOD FOR CORRECTION: Twenty-one	01460		

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01460	Continued From page 14 (21) days	01460		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for two of two employees (assistant manager (AM)-D and unlicensed personnel (ULP)-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: AM-D AM-D was hired on January 2, 2022. During an observation on June 13, 2022, at approximately 10:30 a.m., AM-D was observed assisting R1 with toileting needs.	01480		

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01480	Continued From page 15 AM-D's employee record lacked evidence of resident specific orientation. ULP-E ULP-E was hired on March 10, 2022. During an observation on June 14, 2022, at 8:50 a.m., ULP-E administer R1's oral medications. ULP-E's employee record lacked evidence of resident specific orientation. During an interview on June 14, 2022, at 11:25 a.m., the AM-D and Chief Executive Officer (CEO)-A acknowledged no documentation of resident specific orientation was in any employee records. The licensee provided Staff Orientation and Education Policy dated August 1, 2021, indicated employees providing direct care receive specific orientation to each individual resident and the services to be provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01480		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on	01610		

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01610	Continued From page 16	01610		

which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed a physical and cognitive assessment of a prospective resident on or before move-in for two of two residents (R1 and R2) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R1
R1's Assisted Living Contract was signed on February 7, 2022. R1's diagnoses included Parkinson's.

R1's medical record included a document titled Cannon Country Resident Evaluation, but failed to identify the type of evaluation, and failed to include a RN signature and date.

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01610	Continued From page 17 R2 R2's Assisted Living Contract was signed on February 7, 2022. R2's diagnoses included mild cognitive impairment. R2's medical record included a document titled Cannon Country Resident Evaluation, but failed to identify the type of evaluation, and failed to include a RN signature and date. During an interview on June 13, 2022, at 11:30 a.m., RN-C stated she did not complete an evaluation on R1 and R2 prior to their admit. During an interview on June 14 at 12:35 p.m., CEO-A stated he and the RN that no longer works at the facility had done an evaluation on R1 and R2 prior to their admit. The licensee provided Assessment and Reassessment Policy dated August 1, 2021, indicated the initial RN assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. TIME PERIOD FOR CORRECTION: Seven (7) days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	01620		

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resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed ongoing resident monitoring and reassessment for three of three residents (R1, R2, and R3) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

R1

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01620	Continued From page 19 R1's Assisted Living Contract was signed on February 7, 2022. R1's diagnoses included Parkinson's. R1's medical record included two documents titled Cannon Country Resident Evaluation, neither document identified a type of evaluation. One document had no signature and no date. The second document was signed by a RN that no longer works for the licensee and was dated April 21, 2022. R2 R2's Assisted Living Contract was signed on February 7, 2022. R2's diagnoses included mild cognitive impairment. R2's medical record included a document titled Cannon Country Resident Evaluation, which was incomplete and did not identify a type of evaluation. The medical record also included a document titled Willows, Plummer, Shalom, Weatherstone Uniform Assessment Tool, which did not identify a type of assessment, was incomplete, unsigned, and undated. R3 R3's medical record included a document titled Statement of Home Care Services Comprehensive Home Care Provider signed and dated October 5, 2021, and a document titled The View Fee Agreement signed and dated October 13, 2017. R3' medical record indicated R3's diagnoses included paraplegia. R3's medical record included a document titled Cannon Country Resident Evaluation, which did not identify a type of evaluation. The document was signed by a RN that no longer works for the licensee and was dated October 4, 2021.	01620		

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01620	Continued From page 20 During an interview on June 13, 2022, at 11:30 a.m., RN-C stated she was not in the one doing assessments and has not done any assessments since the last RN quit working for the licensee. During an interview on June 14 at 12:35 p.m., CEO-A stated the RN that was doing the assessments is no longer working for the licensee. The licensee provided Assessment and Reassessment Policy dated August 1, 2021, indicated assessments hall be revised regularly and as appropriate. The policy indicated the RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services and ongoing reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	01650		

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01650	Continued From page 21 (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure resident service plans included the required content for three of three residents (R1, R2, and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included Parkinson's. R1's Assisted Living Contract was signed on February	01650		

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01650	Continued From page 22 7, 2022. R1's medical record included a document titled Exhibit 12 Monthly Schedule of Fees, also signed on February 7, 2022. The document identified fees to include full suite (half-occupancy), meal package, laundry service, housekeeping, and level 5 care service. R2 R2's diagnoses included mild cognitive impairment. R2's Assisted Living Contract was signed on February 7, 2022. R2's medical record included a document titled Exhibit 12 Monthly Schedule of Fees, also signed on February 7, 2022. The document identified fees to include full suite (half-occupancy), meal package, laundry service, housekeeping, and level 2 care service. R3 R3' diagnoses included paraplegia. R3's medical record included a document titled Statement of Home Care Services Comprehensive Home Care Provider signed by R3 and dated October 5, 2021. The document indicated, by a check mark in front of the item, a list of services offered by the provider. The following items were checked: -registered nurse services -medication management services Delegated tasks to unlicensed personnel -hands-on assistance with transfers and mobility -providing eating assistance for clients with complicating eating problems (i.e. difficulty swallowing, recurring lung aspirations, or requiring the use of a tube, parenteral or intravenous instruments) -assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing -providing standby assistance within arm's reach for safety while performing daily activities	01650		

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01650	Continued From page 23 -providing verbal or visual reminders to take regularly scheduled medication (includes bringing clients previously set up medications, medication in original containers, or liquid or food to accompany the medication) -providing verbal or visual reminders to the client to perform regularly scheduled treatments and exercises -preparing modified diets ordered by licensed health professional -laundry -meal preparation -shopping -housekeeping/other household chores R3's medical record also included a document titled The View Fee Agreement signed by R3 and dated October 13, 2017. The document indicated services were provided for rent, services, and garage. R1, R2, and R3's medical record lacked evidence of a service plan that included the following information: -a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences. -the identification of staff or categories of staff who will provide the services. -the schedule and methods of monitoring assessments of the resident. -the schedule and methods of monitoring staff providing services; and -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided. -information and a method to contact the facility. -the names and contact information of persons the resident wishes to have notified in an	01650		

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emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
-the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

During an interview on June 13, 2022, at 11:30 a.m., RN-C stated she had nothing to do with the service plans up to now.

During an interview on June 13, 2022, at approximately 1:20 p.m., CEO-A stated the Exhibit 12 Monthly Schedule of Fees is the service plan.

During an interview on June 13, 2022, at approximately 2:30 p.m., HM-B stated she wasn't sure how the RN was doing it all. HM-B stated they are working on hiring back another RN to help them get things back into place.

The licensee provided Service Plan Policy, dated August 1, 2021, indicated the service plan includes the following:
-a description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party
-the fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences.
-the identification of staff or categories of staff who will provide the services.
-the schedule and methods of monitoring assessments of the resident.
-the schedule and methods of monitoring staff

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01650	Continued From page 25 providing services -a contingency plan that includes the following: -action to be taken if the scheduled service cannot be provided -information and method for a resident or resident's representative to contact the facility -names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition -the identification of and information as to who has authority to sign for the resident in an emergency -circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives TIME PERIOD FOR CORRECTION: Seven (7) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's	01730		

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01730	Continued From page 26 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to develop, maintain, and include a written statement in the service plan, an individualized medication management plan based on the resident's current assessment for two of three residents (R1 and R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37873	A. BUILDING: _____ B. WING _____	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON COUNTRY	308 LARKSPUR LANE 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) COMPLETE DATE
01730	Continued From page 27	01730		

resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1
R1's diagnoses included Parkinson's. R1's medical record included the following documents:
- a Cannon Country Resident Evaluation which included a medication profile on page 10 that was blank.
- a second Cannon Country Resident Evaluation which included a medication profile on page 10 that indicated "see MAR".

R2
R2's diagnoses included mild cognitive impairment. R2's medical record included the following documents:
- a Cannon Country Resident Evaluation, which was six pages and did not include a medication assessment section.
- a Willows, Plummer, Shalom, Weatherstone Uniform Assessment Tool which included a review of medications section on page 13-15 that was blank; but the top of page 16 indicated R2 was deemed unable to safely self-administer medications for the following reasons. The following reasons section was left blank.

R1 and R2's medical record lacked evidence of a medication management plan that included the following information:

- a statement describing the medication management services that will be provided
- a description of storage of medications based

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37873	A. BUILDING: _____ B. WING _____	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON COUNTRY	308 LARKSPUR LANE 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) COMPLETE DATE
01730	Continued From page 28	01730		

on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions
- documentation of specific resident instructions relating to the administration of medications
- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis
- identification of medication management tasks that may be delegated to unlicensed personnel
- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and
- any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

During an interview on June 13, 2022, at 11:30 a.m., RN-C stated she did not complete R1 and R2's assessments or paperwork.

The licensee provided Assessment of Medications Policy, dated August 1, 2021, indicated prior to providing medication management services, Cannon Country will provide an assessment by a registered nurse (RN). The policy further indicated based on the results of the assessment; the RN will document an individualized medication management plan, including the following elements:
- description of medication management service to be provided
- description of medication storage based on resident need, preference, risk of diversion and per manufacturer's direction
- documentation procedures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37873	A. BUILDING: _____ B. WING _____	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON COUNTRY	**308 LARKSPUR LANE 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) COMPLETE DATE
01730	Continued From page 29 - procedures for verification that medications are administered as prescribed - procedures for monitoring medication use to prevent complications or adverse reactions - identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered in a timely manner - identification of medication management tasks delegated to unlicensed staff - procedures for notifying the registered nurse or licensed health profession regarding problems arising with medication management services TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/13/22*
Time: 12:35:16
Report: 1004221141

Food and Beverage Establishment Inspection Report

Location:
Cannon Country
308 Larkspur Lane
Cannon Falls, MN55009
Goodhue County, 25

Establishment Info:
ID #: 0040331
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #: 5072988857
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-300 Personal Cleanliness

2-301.12A ** Priority 1 **

MN Rule 4626.0070A Food employees must clean their hands and exposed portions of their arms for 20 seconds, using soap in a handwashing sink that is properly equipped.

OBSERVED FOOD EMPLOYEE WASH THEIR HANDS FOR LESS THAN 10 SECONDS MULTIPLE TIMES. ENSURE ALL FOOD EMPLOYEES WASH THEIR HANDS FOR A MINIMUM OF 20 SECONDS AT ALL TIMES.

Comply By: 06/13/22

2-300 Personal Cleanliness

2-301.12B ** Priority 1 **

MN Rule 4626.0070B Food employees must use the following procedure when cleaning their hands and exposed portions of their arms: rinse their hands under clean, warm running water; apply hand soap to their hands; rub their hands together vigorously for at least 10 to 15 seconds; remove soil from beneath fingernails while cleaning their hands; thoroughly rinse their hands under clean, warm running water; and thoroughly dry their hands with: 1) individual, disposable towels, 2) a continuous towel system that supplies the user with a clean towel, 3) a heated-air hand drying device, or 4) a hand drying device that employs an air-knife system that delivers high velocity, pressurized air at ambient temperatures.

OBSERVED FOOD EMPLOYEE USING A SINGLE CLOTH TOWEL TO DRY HANDS AFTER WASHING MULTIPLE TIMES. DISCONTINUE USING CLOTH TOWEL TO DRY HANDS AND USE PAPER TOWELS OR OTHER APPROVED MEANS.

Comply By: 06/13/22

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

ESTABLISHMENT HAS A 3-COMPARTMENT KITCHEN SINK. EMPLOYEE STATED LEFT SINK BASIN WAS DESIGNATED FOR HANDWASHING, BUT MULTIPLE ITEMS WERE STORED IN THE SINK BASIN. DO NOT USE DESIGNATED HANDWASHING SINK BASIN FOR ANY ACTIVITIES BESIDES HANDWASHING.

Comply By: 06/13/22

2-300 Personal Cleanliness

2-301.12C

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.

OBSERVED THE FOOD EMPLOYEE TURNING OFF THE HANDWASHING SINK FAUCET WITH THEIR HANDS AFTER WASHING. ENSURE A PAPER TOWEL, OR OTHER APPROVED BARRIER, IS USED TO TURN THE HANDWASHING SINK FAUCET OFF AFTER WASHING TO PREVENT RECONTAMINATION OF HANDS.

Comply By: 06/13/22

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at >170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BACON
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR (HOUSEHOLD)
Violation Issued: No

Process/Item: HAM
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR (HOUSEHOLD)
Violation Issued: No

Process/Item: PORK LOIN
Temperature: 40 Degrees Fahrenheit - Location: GARAGE REFRIGERATOR (HOUSEHOLD)
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	1

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY LISA COIL.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING

-PREVENTING BAREHAND CONTACT
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DISH MACHINE SANITIZING TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES (SAME DAY PREPARE AND SERVE)
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH OPERATOR ON SITE AND THE NURSE EVALUATOR, LISA.

*FLOORS ARE LAMINATE WOOD, WALLS ARE PAINTED DRY WALL, AND CEILING IS TEXTURED. COUNTERTOPS CONSIST OF STONE AND WOOD AND CABINETS ARE HALLOW BASE LACQUERED WOOD. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004221141 of 06/13/22.

Certified Food Protection Manager: ASHLYN B. HALLMAN

Certification Number: FM109506 Expires: 01/27/25

Signed: _____
Establishment Representative

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us