CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

					AND TRANSMITTAL FE SURVEY AGENCY	ID: SW7U Facility ID: 00758	
MEDICARE/MEDICAID PROVIDER NO. (L1) 245304 2.STATE VENDOR OR MEDICAID NO. (L2) 847972200 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 03/01/2016		3. NAME AND ADDRESS OF FACILITY (L3) THE GARDENS AT CANNON FALLS (L4) 300 NORTH DOW STREET (L5) CANNON FALLS, MN 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		(L6) 55009 <u>02</u> (L7) 13 PTIP 22 CLIA	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint		
	7/ 2020 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	89 (L18) 89 (L17)	X A. In Complian Program F Complian 1. B. Not in Complian	IS CERTIFIED AS: ance With Requirements ce Based On: Acceptable POC ampliance with Progra and/or Applied Waiv	am	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code * Code: A 15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director	
18 SNF 18/19 SNF 89 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMA Effective December 29, 2019, due change in licensure. After this cha	to15 beds being rel	icensed, the number	of licensed and c		ds in your facility are increased f	rom 74 beds to 89 beds in accordance with a	
Eva Loch, Unit Sup	ervisor	Date :	01/24/2020	(L19)	18. STATE SURVEY AGENCY APPROVAL Douglas Larson, Enforcement Specialist 01/24/2020 (L20		
]	PART II - TO BE	COMPLETED	BY HCFA RE	GIONAL	L OFFICE OR SINGLE ST		
DETERMINATION OF ELIGIBILI 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		MPLIANCE WITH C	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) :	
22. ORIGINAL DATE OF PARTICIPATION 02/01/1986 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATI A. Suspension B. Rescind Sus	DATE VE SANCTIONS of Admissions:	4. LTC AGREEMI ENDING DATE (L25) (L44)		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/0	CARRIER NO.		30. REMARKS		
	(L28)	06201		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL DA	TE			

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

01/07/2020

(L32)



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 24, 2020

CMS Certification Number (CCN): 245304

Administrator The Gardens 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 December 29, 2019 the above facility is certified for:

89 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 89 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,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Down Starson

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 24, 2020

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

RE: CCN: 245304

Cycle Start Date: October 10, 2019

Dear Administrator:

On December 6, 2019, we notified you a remedy was imposed. On January 17, 2020 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 December 29, 2019.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective December 29, 2019 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 31, 2019, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 29, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 29, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Douglas Larson, Enforcement Specialist

Minnesota Department of Health

Jovens Stapson

Licensing and Certification Program

The Gardens At Cannon Falls January 24, 2020 Page 2

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

THE HEIMEN SERVICES	CENTERS I OR MEDICINE &	WILDICAID SERVI
MEDICARE/MEDICAID CERTIFICATION AN	ID TRANSMITTAL	ID: SW7U

	PART I -	TO BE COMPI	LETED BY T	THE STAT	E SURVEY	AGENCY		Facility ID: 00758
MEDICARE/MEDICAID PROVIDER (L1) 245304 2.STATE VENDOR OR MEDICAID NO (L2) 847972200		3. NAME AND AD (L3) THE GARD (L4) 300 NORTH (L5) CANNON E	ENS AT CAN	NON FALI		55009	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9) 03/01/2016		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey Afto	9. Other er Complaint
6. DATE OF SURVEY 11/12/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR END 09/30	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	74 (L18) 74 (L17)	Compliance1. A X B. Not in Con	equirements e Based On:	gram	2. Tecl 3. 24 H 4. 7-D 5. Life	hnical Personnel Hour RN ay RN (Rural SN Safety Code	The Following Requiren 6. Scope of S 7. Medical D F) 8. Patient Roc 9. Beds/Room (L12)	Services Limit Prirector Om Size
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 74 (L37) (L38)	N 19 SNF (L39)	ICF (L42)	IID (L43)	waiveis.	* Code: 15. FACILITY 1861 (e) (1) o		(L15)	
16. STATE SURVEY AGENCY REMARE Effective December 29, 2019, due with a change in licensure. After the 17. SURVEYOR SIGNATURE	to15 beds being	g relicensed, the nur	mber of license	d and certif		r facility are inc		to 89 beds in accordance Date:
Sandra Tatro, HFE I	NE II	1	2/31/2019	(L19)	Melissa Poe	pping, Enforce	ement Specialist	01/07/2020 (L20)
PART	TII - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE O	R SINGLE S	FATE AGENCY	
19. DETERMINATION OF ELIGIBILIT _X 1. Facility is Eligible to Par 2. Facility is not Eligible			IPLIANCE WITI HTS ACT:	H CIVIL	2. (ncial Solvency (HCFA-25 I Interest Disclosure Stm :	
22. ORIGINAL DATE OF PARTICIPATION 02/01/1986	23. LTC AGREE		4. LTC AGREEN ENDING DA		VOLUNTARY 01-Merger, Clos		05-Fail to	(L30) NTARY Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	A. Suspension	VE SANCTIONS n of Admissions: uspension Date:	(L25) (L44) (L45)			on W/ Reimburse untary Terminatio n for Withdrawal	n <u>OTHER</u>	Meet Agreement der Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	ļ		
	(L28)	06201		(L31)				
31. RO RECEIPT OF CMS-1539		. DETERMINATION	I OF APPROVAL					
	(L32)			(L33)	DETERMIN	ATION APPE	ROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 6, 2019

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

RE: CCN: 245304

Cycle Start Date: October 10, 2019

Dear Administrator:

On October 31, 2019, we informed you that we may impose enforcement remedies.

On November 12, 2019, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby 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 December 29, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 29, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 29, 2019.

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

The Gardens At Cannon Falls December 6, 2019 Page 2 payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

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 \$10,483; 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 December 29, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Gardens At Cannon Falls will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 29, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. 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" tag), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Eva Loch, Unit Supervisor
Metro D Survey Team
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: eva.loch@state.mn.us

Phone: (651) 201-3792 Fax: (651) 215-9697

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 April 10, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

DOUBLES STARROW

Douglas Larson, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 12/23/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		CONSTRUCTION	COMPLETED		
		245304	B. WING				C 12/2019
	PROVIDER OR SUPPLIER	FALLS		300	REET ADDRESS, CITY, STATE, ZIP CODE NORTH DOW STREET NNON FALLS, MN 55009		12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	Emergency Prepar conducted from 11 a recertification sur		F 0	00			
	was conducted at y investigations were was found not to be requirements of 42 Requirements for L The following companies substantiated: H5304060C deficients H5304061C deficients was found not to be requirements of 42 Requirements for L	h 11/12/19, a standard survey your facility. Complaint also conducted. Your facility in compliance with the CFR 483, Subpart B, Long Term Care Facilities. Colaints were found to be ency issued at F689 ency issued at F689 ency issued at F689 ency issued at F689					
	H5304064C deficie H5304065C substatissued at F689 H5304066C deficie H5304067C deficie H5304069C deficie F610	ency issued at F689 ency issued at F755 antiated with an associated tag ency issued at F689 ency issued at F689 ency issued at F744, F609, ency issued at F689					
	Complaint H53040 unsubstantiated	68C was found to be					
	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Because you are					
ABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed 12/17/2019

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245304	B. WING			C / 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	at the bottom of the form. Your electron be used as verifica	your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.	F 0	00		
F 561 SS=D	on-site revisit of yo validate that substate regulations has been your verification. Self-Determination		F 5	61		12/29/19
	promote and facilitathrough support of	ne right to and the facility must ate resident self-determination resident choice, including but ghts specified in paragraphs (f)				
	activities, schedule waking times), hea care services cons	resident has a right to choose s (including sleeping and lth care and providers of health istent with his or her interests, plan of care and other his of this part.				
	choices about aspe	resident has a right to make ects of his or her life in the hificant to the resident.				
	with members of th	resident has a right to interact be community and participate in as both inside and outside the				
		resident has a right to activities, including social,				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	` ´COM	(X3) DATE SURVEY COMPLETED	
		245304	B. WING			C 12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
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F 561	Continued From pa	age 2	F 56	1			
	interfere with the rig facility. This REQUIREME by:	munity activities that do not ghts of other residents in the NT is not met as evidenced tion, interview and document		Preparation and execution of th	is		
	review, the facility the preference for beding reviewed for choice	failed to accommodate resident time for 1 of 2 residents (R46)		response and plan of correction constitute an admission or agree the provider of the truth of the fa alleged or conclusions set forth	does not ement by cts in the		
		on 11/4/19, at 6:06 p.m. sitting v/c) in his room with his call s door.		statement of deficiencies. The p correction is prepared and/or ex solely because it is required by t provisions of federal and state at the purposes of any allegation the center is not in substantial comp	ecuted he aw. For nat the		
	R46's cognition wa paraplegia (paralys Annual MDS indica Dependence two s	dated 10/4/19, indicated s intact with a diagnosis of sis of the lower body). R46's ated R46 needed Total taff assistance with transfers staff assistance with dressing,		with federal requirements of par this response and plan of correct constitutes the centers allegation compliance in accordance with s 7305 of the State Operations Ma	ticipation, tion n of section		
	under Section E- Ir was marked (-) for	, bathing. R46's MDS indicated hterview for Daily Preferences the interview question "How e your own bedtime?"		1.It is the policy of the facility to resident choices are honored. R R46 was interviewed and his cal was updated to reflect his choice Kardex also was updated with R	esident re plan es. The		
	room two times wit	S p.m. a staff walked by R46's hout entering R46's room.		preferences. All residents and/o are interviewed for preferences and services upon admission, q	of care uarterly,		
	hallway and told re answer R46's call I needed. RN-A (who entered R46's room on. -At 6:19 p.m. R46 p his doorway to the	tor of nursing (DON) stood in gistered nurse (RN)-A to ight and to see what R46 to was also nurse manager) in and exited and left call light propelled himself in his w/c out hall with his call light on.		annually and with significant chapart of the RAI Process. The cand Kardex reflect their preferer 2. All current residents have bee reviewed for current preference assessment and reassessed as Care plans reviewed and update reflect current preference needs the potential to affect all facility residents.	needed. This has		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 20122			С	
		245304	B. WING			11/1	12/2019
	PROVIDER OR SUPPLIER	FALLS		30	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	DON it was R46 was call light was on an as she had opened over herself and als the toilet. DON told the lift while DON v be helped after R46-At 6:25 p.m. an un R46's room pushin inquiring what R46 were four call lights hallway while RN-A activity staff (ACT)-(LPN)-C were talkin station. DON told N room." -At 6:27 p.m. two u room with the trans-At 6:27 p.m. DON R23 she would nee her to bed "Soon, to ahead of you." -At 6:28 p.m. DON asked him if he was NAs went into R4's tired and wanted to Chicago PD is com-At 6:29 p.m. R46's off, DON in R46's room. The company of the results of the	nose call light is on?" NA told aiting to go to bed but R10's d she wanted staff assistance and spilled a coca cola all so wanted assistance to go to NA to go and hook up R46 to vent and told R10 she would was assisted. Identified staff walked past go a resident in a w/c without needed. At 6:25 p.m. there is activated on in the 200 was seated in her office, and was reach other at nurse late. If will meet you in R46's nidentified NAs entered R4's fer lift. If was entered R23's room and told at to wait and staff would help here are people [residents] entered R46's room and sated the room with the lift. R46 he was get into bed and my program ing on television. It call light over his door went soom. exited R46's room and stated the how much longer it would istance to bed. It was observed sitting in his w/c	F 5	561	3.Staff will be in-serviced on reside rights with self-determination and con 12/20/2019. 4.The director of nursing or designe be responsible for compliance. Authorized to ensure resident chare honored to prevent reoccurrent this deficiency daily x 4 weeks, were and then monthly x 1. Results will be reviewed by our Quality committee further recommendation.	ee will dits will noices ce of ekly x 4	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _		11	/ 12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 300 NORTH DOW STREET CANNON FALLS, MN 55009	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 561	light onAt 6:33 p.m. no c -At 6:33 p.m. R46 room to go to bed -At 6:38 p.m. R10 over their room do -At 6:40 p.m. R46 room into hallway told R46 she could while he was waiti -At 6:44 p.m. R46 in his room with R transfer liftAt 6:47 p.m. NA v RN-A to transfer F minutes for staff a -At 7:18 p.m. R46 go to bed at 6:00 p	all lights activated in hall 200 observed still waiting in his and R54's call lights came on ors. wheeled himself out of his looking down hallway. RN-Ad get R46 hooked up to the lifting. was observed sitting in his w/c N-A present hooked up to the walked into R46's room to assist R46 to bed. (R46 waited 41	F 56	31			
	many lifts and too enough staff and that to wait over all bed. NA-B stated at the last step of first and the reside last. NA-B stated that wash residents upgenerally the normal LPN-C stated on a could not be composed and generally could only two NAs instead.	/5/19, at 2:32 p.m. there too many behaviors and not hat was why some residents in hour to get help to get into residents who needed less care the process to bed went to bed ents who required more steps there was not enough staff to in NA-B stated that was in here at the facility. 1/6/19, at 2:21 p.m. showers pleted when only having two dollast Sunday only had two NAs pole times a pay period ran with ead of three NAs. LPN-C stated on the NAs for turning off call					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245304	B. WING _			C 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		12/2010
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 561	R46 gets left to the leave him and since price. LPN-C stated manager aren't ans R46's careplan date R46's preference for RN-A nurse manage p.m. R46 can go to knew that. RN-A statime was not identife "as staff just know IDON stated on 11/3 go to bed at 6:00 p. DON stated staff she follow residents' care Facility policy Self E Participation dated would be allowed to consistent with thei including sleeping. facilitate resident of information about reupon initial assessment the medical record. Facility policy undatindicated staff would as soon as possible requests and needs	end and staff leave tend to end and staff leave the discount of the call lights. end 11/7/19, did not include or bedtime at 6:00 p.m. eter, stated on 11/7/19, at 2:26 bed at 6:00 p.m. and all staff leated R46's preference for bed fied on R46's NA care sheet by word of mouth." 7/19, at 2:45 p.m. R46 could lead and accommodate this and replan. Determination and 7/25/16, indicated residents on choose schedules that are interest for daily routine. The policy indicated to noice staff would gather esidents' personal preferences ment and periodically ument these preferences in the call Light danswer residents' call lights end respond to residents' is.	F 56			12/20/10
	Resident/Family Gr CFR(s): 483.10(f)(5		F 50	io.		12/29/19

PRINTED: 12/23/2019 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		245304	B. WING			11/1	12/2019	
	PROVIDER OR SUPPLIER RDENS AT CANNON	FALLS		30	TREET ADDRESS, CITY, STATE, ZIP CODE O NORTH DOW STREET ANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 565	§483.10(f)(5) The rand participate in ro (i) The facility must group, if one exists reasonable steps, to make residents a upcoming meetings (ii) Staff, visitors, or resident group or fathe respective grout (iii) The facility must person who is appr group and the facility requests that result (iv) The facility must resident or family gethe grievances and groups concerning in the facility. (A) The facility must response and ration (B) This should not facility must implen request of the resident of the resident or family \$483.10(f)(6) The reparticipate in family \$483.10(f)(7) The representative(s) representative(s) residents in the factor This REQUIREMED by: Based on observations.	esident has a right to organize esident groups in the facility. provide a resident or family, with private space; and take with the approval of the group, and family members aware of an in a timely manner. To other guests may attend amily group meetings only at p's invitation. It provide a designated staff oved by the resident or family ty and who is responsible for the and responding to written a from group meetings. It consider the views of a roup and act promptly upon recommendations of such issues of resident care and life at be able to demonstrate their male for such response. The beconstrued to mean that the ment as recommended every lent or family group. The esident has a right to have or other resident neet in the facility with the representative(s) of other illity. The interview and document the series are evidenced.	F	565	1.Resident Council members were			
	review, the facility f	ailed to promptly respond to vances for long call light wait			to meet on 12/13/2019 to address t grievance process. They were infor			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		E SURVEY PLETED
		245304	B. WING			C 11/12/2019	
	PROVIDER OR SUPPLIER	FALLS		30	REET ADDRESS, CITY, STATE, ZIP CODE 0 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 565	times for 8 of 9 res R18, R22, R24, R3 Findings include: During resident cor 2:08 p.m. R1, R3, I stated they waited to be answered, up waited for staff ass R18, R24, R37 star problem in the facil getting worse the lastated nothing had with the problem. Resident Council (I identified residents expressed call light timely manner. RC assistants (NA)s to ignored residents was completed for regarding call light. RC minutes dated lights not being answered in the resident of the residents of the regarding call residents of the regarding call light. RC minutes dated lights not being answered in the regarding answered minutes to 1 hour ferminutes to 1 hour ferminutes.	idents (R1, R3, R12, R51, identify) in Resident Council. Juncil meeting on 11/6/19, at R12, R51, R18, R24, R37 a long time for their call lights to an hour and longer they istance. R1, R3, R12, R51, ted long call lights had been a lity since last spring, and was ast couple of months, and been changed or done to help RC) minutes dated 4/24/19, present at the April meeting ts were not answered in a comembers stated nursing lights and who activated their call lights. The resident council complaints concerns. Journal of the call lights and still being assistance provided. A letter conding to RC members did not with call lights. May 10/26/19, identified call lights din a timely manner waiting 45 or staff assistance, and staff lights without talking to the	F 5	565	on what the facility is doing to resol their grievances on 11/13/2019. Or all Resident Council grievances wil address within five working days wiresult posted on the resident bulleti board until the next Resident Counmeeting 2. All these grievances and any new grievances will be reviewed at the rQAPI meeting on 12/19/2019. 3. Management staff have been inson 12/13/2019 on the grievances pand procedures. Then all remaining were in-service by 12/29/2019. 4. The Social Service Director or dewill be responsible for compliance will be completed on grievances to prevent reoccurrence of this deficite weekly x 4, then monthly x 2. Resulbe reviewed by our QAPI committee further recommendations	ngoing I be ith the in cil v next service olicy g staff esignee Audits ency ts will	

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED			
		245304	B. WING		1	C 1/12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 565	RC minutes dated were frustrated over call light concerns them. RC minutes dated regarding call lights RC minutes dated regarding call lights RC minutes dated been no follow up of times and staff behavior and staff behavior call light wait to buring interview with p.m. DON stated in audits to determine resident request folights. During interview with at 2:28 p.m. he staff concerns and staff behavior call light regarding residents wait time for staff at Facility policy undaindicated staff would redicated staff would redic	7/31/19, identified residents or no resolution to the same and nothing being done about 8/28/19, did not note anything or staffing. 9/25/19, did not note anything or staffing. 10/10/19, identified there had done for long call light wait naviors. 10/30/19, identified on been given timely and up had been done regarding imes and staff behaviors. th DON on 11/8/19, at 1:02 ursing had completed no estaff response time for restaff assistance with the call the administrator on 11/12/19, at deed he did not read the monthly ated each department head or follow up with concerns from conthly meetings. Administrator audits had been completed so concerns with long call light assistance. ted, Answering the Call Light lights eand respond to residents'	F 5	65		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245304	B. WING		11	C / 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	112/2010
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F 565	Continued From pa	age 9 ated 10/10/19, indicated the	F 5	65		
F 578 SS=D	facility encouraged Resident Council a other residents to o The policy indicate addressed in a sati	all residents to utilize the is an opportunity to meet with discuss any area of concern. It desidents' concerns would be isfactory and timely manner. It is scotting the second of the s	F 5	78		12/29/19
	discontinue treatme	right to request, refuse, and/or ent, to participate in or refuse perimental research, and to nce directive.				
	construed as the ri the provision of me	ning in this paragraph should be ght of the resident to receive edical treatment or medical nedically unnecessary or				
	requirements spec subpart I (Advance (i) These requirements inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable State (iii) Facilities are pre- entities to furnish the legally responsible requirements of this (iv) If an adult indiversity in the support support of the support	ents include provisions to written information to all adult on the right to accept or refuse a treatment and, at the formulate an advance directive, written description of the implement advance directives to law. Exermitted to contract with other his information but are still for ensuring that the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245304	B. WING			11/1	C 12/2019
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 1/1	12/2019
TO TWIL OF T	NOVIDEN ON COLL FIEN				00 NORTH DOW STREET		
THE GAR	RDENS AT CANNON	FALLS			ANNON FALLS, MN 55009		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 578	Continued From pa	age 10	F 5	578			
		ulate whether or not he or she					
		dvance directive, the facility					
		directive information to the					
		t representative in accordance					
	with State Law.	at relieved of its obligation to					
		ot relieved of its obligation to ation to the individual once he					
		ceive such information.					
		res must be in place to provide					
		he individual directly at the					
	appropriate time.						
		NT is not met as evidenced					
	by:	C			A T1 - 6 - 116		
		tion, interview and document			1.The facility recognizes the reside		
		ailed to ensure an accurate d to include appropriate code			right under state law to make decis concerning medical care, including		
		wishes for life-saving			right to accept or refuse medical	uic	
		ent) regarding cardio			treatment, and the right to formulate	е	
		ation (CPR) for 1 of 12			Advance Directives. The facility ag		
		viewed for Advance Directives.			honor decisions concerning medica		
					including the right to accept and ref		
	Findings include:				treatment, when made in accordan		
	D401 END / 1 /				state law. R42 had code status veri		
		onic medical record) was /19. R42's EMR identified he			ensure accuracy by the nurse pract		
		s (indication to initiate CPR).			The POLST, physician orders and oplan were verified and updated. All		
	was run-code statu	s (indication to initiate of 17).			resident charts were audited to ens		
	R42's physician ord	ders dated 10/31/19, identified			code status forms were complete a		
	R42 had full code s				corresponded with MD orders. Care		
					were reviewed and updated as nee	ded.	
		sician Order for Life Sustaining			2.All current residents have been		
		identified R42's code status			reviewed for current POLST and up		
		not resuscitate/do not			as needed. Care plans reviewed ar		
		ST form was signed by RN)-A and R42's physician, and			updated to reflect current POLST re This has the potential to affect all fa		
		nt POLST in R42's EMR.			residents	acility	
		is not written on the document.			3.Nursing staff, and social services	has	
		s.r tilo document.			been in-serviced on the Facility Gui		
	Interview on 11/5/1	9, at 1:42 p.m. with licensed			for Code Status and Advance Direct		
ORM CMS-25	567(02-99) Previous Versions	s Obsolete Event ID: SW7U1	11	Fac	cility ID: 00758 If continuatio	n sheet Pa	age 11 of 152

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245304	B. WING _			12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COL 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 578	indicated R42 had if R42 arrested, the status was to look status was not ider stated she used the EMR scanned doc. During interview or stated he wanted to breathing and his had breathing and agreed it could incorrect resuscitate cardiopulmonary and the director of nursus had breathing to reside verified R42 continual full-code status. Dochanged R42's code electronic medical 5/23/19, POLST. Reparty and was re-ir remain full code, so be changed back to agreed staff had the	N)-D identified R42's EMR full code status. LPN-D stated equickest way to identify code in R42's EMR. If the code in R42's EMR. If the code in R42's EMR, LPN-D expense recent POLST in the aments. 111/5/19, at 1:54 p.m. R42 to be resuscitated if he stops leart stops. Viewed again on 11/5/19. The 2's code was DNR/DNI. 111/5/19, at 4:10 p.m. with was unsure why R42 had a ne was DNR/DNI in the chart, I cause R42 to receive the cion measures if he had rest. Sing (DON) was interviewed on m. and stated she expected the POLST to ensure appropriate ures were implemented ent and family choices. DON used to choose to maintain DN confirmed she had just the status to DNR in his record after reviewing his record after reviewing his record after reviewing his code status was going to the potential to deliver the cive measures with conflicting interviewed w	F 57	4. The director of nursing or debe responsible for compliance be completed to ensure reside status and POLST are accura documented correctly in the elmedical record weekly x 4 and monthly x 2. Results will be reour Quality committee for furth recommendation.	e. Audits will ent code te and lectronic I then viewed by	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING			C 11/12 /	/2019
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009	DDE	11/12/	2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	_	(X5) OMPLETION DATE
F 578	stated she was the coordinator, and vand orientation. So about the crash castatus. SD stated most recent POLS the EMR because accurate and curresident's code starole for about a yewas responsible for staff about the fact facility's code state RN-B was not family status policies and reviewed with staff Additionally, RN-Edocumentation co	page 12 In 11/5/19, at 4:21 p.m. RN-B is e staff development (SD) Ivas responsible for staff training the instructed new licensed staff art and where to identify code she expected staff to use the ST rather than information from the POLST was the most ent document identifying a atus. She had worked in her ear, and was unsure how or who for educating existing licensed fility's crash cart, and the sus policies and procedures. Iniliar with the facility's code d procedures, which were not if on a routine basis. It is verified she had no de status education was facility and agency staff upon	F 5	78			
	-A indicated reside complete advance POLST was proving residents to estable directives upon acceptive duraterly with significant chospitalization. The responsible for upof each resident's responsible to ensuration decision necessary signature updated and accuplan and physicial	ents were encouraged to end directives upon admission. A ded and reviewed with new lish code status and health care dmission. Code status was y, and on an as-needed basis, anges in status, and after ne nurse managers (NM) were endating and ensuring accuracy code status. NM were also sure the resident and/or s were documented with all lares, included on the POLST, rate in the residents EMR, care in orders. SW-A was unsure of cesses in place to ensure					

NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS SITECT ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009 EACH DEFICIENCY MUST SEE PRECEDED BY PLU. REGULATORY OR LSC IDENTIFYING INFORMATION) F578 Continued From page 13 accurate code status documentation, R42's wishes were reviewed at quarterly care conferences and he chose to be full code. SW-A stated at one point R42 was agreeable to change to DINR Status, but was unsure if his status had actually changed. R42 was his own person, and made his own decisions regarding medical decisions. SW-A verified R42's most recent POLST in the EMR identified him as DINR/DINI, but was only signed by RN-A and R42's physician. SW-A was unaware the POLST for DINR/DINI was placed in R42's medical record, was unsure why it lacked the resident/guardian signature. The Advanced Directives policy dated 1/9/19, indicated the social service director was responsible for implementing and coordinating procedures to obtain residents' code status. Code status was obtained verbally from the resident, hospital, medical record, or resident advanced directive documents. After obtaining code status, the information was entered into the EMR for physician review and signature. Advance Directives were reviewed and updated upon readmission and as needed, on at least a quarterly basis, with the resident's plan of care. POLST information was obtained and added to all resident chairs upon admission, and were able change per resident choice. Facility staff were not authorized to give legal or medical advice regarding Advanced Directives. Facility staff responsibilities were to provide written materials upon admission and request to help residents Advanced Directives. Facility staff responsibilities were to provide written materials upon admission and request to help residents Advanced Directives. Facility staff responsibilities were to provide written materials upon admission and septiced to the resident to the residents family, physician, and outside resources. T	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
THE GARDENS AT CANNON FALLS THE GARDENS AT CANNON FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREEN TAG FOR Continued From page 13 accurate code status documentation, R42's wishes were reviewed at quarterly care conferences and he chose to be full code, SW-A stated at one point R42 was agreeable to change to DNR Status, but was unsure if his status had actually changed, R42 was his own person, and made his own decisions regarding medical decisions. SW-A werlified R42's most recent POLST in the EMR identified him as DNR/DNI, but was only singed by RN-A and R42's physician. SW-A was unsured why it lacked the resident/guardian signature. The Advanced Directives policy dated 1/9/19, indicated the social service director was responsible for implementing and coordinating procedures to obtain residents; code status, the information was entered into the EMR for physician review and signature. Advanced Directives were reviewed and updated upon readmission and as needed, on at least a quarterly basis, with the resident's plan of care. POLST information was obtained and added to all resident charts upon admission, and were able change per resident choice. Facility staff were not authorized to give legal or medical advice regarding Advanced Directives. The resident, saff responsibilities were to provide written materials upon admission and request to help residents. Advanced Directives. If a resident thad questions, staff referred a resident to the resident's family, physician, and outside resources. The policy did			245304	B. WING _			C /12/2019		
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 13 accurate code status documentation. R42's wishes were reviewed at quarterly care conferences and he chose to be full code. SW-A stated at one point R42 was agreeable to change to DNR Status, but was unsure if his status had actually changed. R42 was his own person, and made his own decisions regarding medical decisions. SW-A verified R42's most recent POLST in the EMR identified him as DNR/DNI, but was only signed by RN-A and R42's physician. SW-A was unaware the POLST for DNR/DNI was placed in R42's medical record, was unsure why it lacked the resident/guardian signature. The Advanced Directives policy dated 1/9/19, indicated the social service director was responsible for implementing and coordinating procedures to obtain residents code status. Code status was obtained verbally from the resident, hospital, medical record, or esident advanced directive documents. After obtaining code status, the information was entered into the EMR for physician review and signature. Advance Directives were reviewed and updated upon readmission and as needed, on at least a quarterly basis, with the resident's plan of care. POLST information was obtained and added to all resident choice. Facility staff reprendent plan of care regarding Advanced Directives. Facility staff responsibilities were to provide written materials upon admission and request to help residents Advanced Directives. Facility staff responsibilities were to provide written materials upon admission and request to help residents Advanced Directives. Facility staff responsibilities were to provide written materials upon admission and request to help residents Advanced Directives. Facility staff responsibilities were to provide written materials upon admission and request to help residents.					300 NORTH DOW STREET		12/2010		
accurate code status documentation. R42's wishes were reviewed at quarterly care conferences and he chose to be full code. SW-A stated at one point R42 was agreeable to change to DNR Status, but was unsure if his status had actually changed. R42 was his own person, and made his own decisions regarding medical decisions. SW-A verified R42's most recent POLST in the EMR identified him as DNR/DNI, but was only signed by RN-A and R42's physician. SW-A was unsware the POLST for DNR/DNI was placed in R42's medical record, was unsure why it lacked the resident/guardian signature. The Advanced Directives policy dated 1/9/19, indicated the social service director was responsible for implementing and coordinating procedures to obtain residents' code status. Code status was obtained verbally from the resident, hospital, medical record, or resident advanced directive documents. After obtaining code status, the information was entered into the EMR for physician review and signature. Advance Directives were reviewed and updated upon readmission and as needed, on at least a quarterly basis, with the resident's plan of care. POLST information was obtained and added to all resident charts upon admission, and were able change per resident choice. Facility staff were not authorized to give legal or medical advice regarding Advanced Directives. Facility staff responsibilities were to provide written materials upon admission and request to help residents Advanced Directives. Facility staff responsibilities were to provide written materials upon admission and request to help residents Advanced Directives. If a resident to the resident's family, physician, and outside resources. The policy did	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUNDS CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION		
	F 578	accurate code state wishes were review conferences and he stated at one point to DNR Status, but actually changed. If made his own decidecisions. SW-A we POLST in the EMF but was only signed physician. SW-A we DNR/DNI was placed was unsure why it signature. The Advanced Dirindicated the social responsible for improcedures to obtain status was obtained hospital, medical redirective document the information was physician review and Directives were reviewed made and the information was physician review and procedures to give a procedure to give and the information was physician review and physician and and the responsibilities were upon admission and Advanced Directive staff referred a responsician, and outs	wed at quarterly care e chose to be full code. SW-A R42 was agreeable to change was unsure if his status had R42 was his own person, and sions regarding medical erified R42's most recent didentified him as DNR/DNI, d by RN-A and R42's reas unaware the POLST for red in R42's medical record, lacked the resident/guardian rectives policy dated 1/9/19, I service director was blementing and coordinating in residents' code status. Code d verbally from the resident, ecord, or resident advanced ts. After obtaining code status, s entered into the EMR for and signature. Advance viewed and updated upon s needed, on at least a h the resident's plan of care. In was obtained and added to all on admission, and were able and choice. Facility staff were not legal or medical advice and Directives. Facility staff are to provide written materials and request to help residents and request to help residents and resident had questions, ident to the resident's family, side resources. The policy did	F 57	8				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			C (X3) DATE SURVEY	
		245304	B. WING _			12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 578	a process to ensure status. The Emergency Processive and the processing and the processing and the statement of the statemen	ce accuracy of resident code cocedure-Cardiopulmonary y and procedure dated 8/3/16, dure for administering CPR ceps in the 2010 American Guidelines for desuscitation and Emergency re for facility BLS (basic life terial. The policy and include a process for how staff ode status in the event of monary arrest. It also indicated conduct periodic mock codes to g to an arrest. Itable/Homelike Environment)-(7) vironment. Iright to a safe, clean, melike environment, including ceiving treatment and ving safely. ovide- e, clean, comfortable, and ent, allowing the resident to onal belongings to the extent	F 58	8		12/29/19
	receive care and se physical layout of the independence and (ii) The facility shall	suring that the resident can ervices safely and that the ne facility maximizes resident does not pose a safety risk. exercise reasonable care for e resident's property from loss				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245304	B. WING		1.	C / /12/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		111212013
THE GAI	RDENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 584	services necessary and comfortable into §483.10(i)(3) Clear in good condition; §483.10(i)(4) Private resident room, as so §483.10(i)(5) Adequevels in all areas; §483.10(i)(6) Comflevels. Facilities initi 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMED by: Based on observate review, the facility of a missing ring for 1 for missing personal findings include: R254's Minimum Dindicated R254 was hospital with diagon hepatitis and withdoweakness after falliced. The MDS inclinated.	ekeeping and maintenance to maintain a sanitary, orderly, terior; a bed and bath linens that are te closet space in each specified in §483.90 (e)(2)(iv); that and comfortable lighting to table and safe temperature tially certified after October 1, in a temperature range of 71 to the maintenance of comfortable NT is not met as evidenced tion, interview and document ailed to follow up on a report of of 2 residents (R25) reviewed	F 5	1.R25 discharge from this f 11/12/2019 when he got hor the ring in a drawer that he to surveyors to have lost. S report R25 concern on a grievance/concern form to a missing ring and to investiga concern. 2.All these grievances and a grievances will be reviewed QAPI meeting on 12/19/201 3.Management staff have be on 12/13/2019 on the grieva and procedures. Then all re were in-service by 12/29/20 4.The Social Service Director will be responsible for comp	me he found had reported staff failed to alert staff of ate his any new at the next 19. een in-service ances policy emaining staff 19. or or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245304	B. WING_			C 12/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 584	increase strength home. During an ir p.m. R254 indicate the top drawer of t R254 stated the rir sandwich-sized plamissing in mid Oct as gold with an am R254 stated the rir wedding ring from his father's and his the cost of the ring the ring was mostl stated the missing Director of Social Snoticed it was miss nothing that could did not know if it w DSS was interview and verified R254 but stated there was because the ring we personal property admission. DSS in retrieve the invente but thought it just be requested a copy for were told to keep to the value or if R254 LPN-G and LPN-F at 2:32 p.m. and no missing ring.	with a plan to discharge to nterview on 11/4/19, at 4:30 at he was missing a ring from the nightstand next to the bed. In the head of the	F 58	will be completed on grieval prevent reoccurrence of this weekly x 4, then monthly x be reviewed by our QAPI of further recommendations.	is deficiency 2. Results will	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C		
		245304	B. WING		11	/ 12/2019		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009	•			
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F 584	Continued From pa	age 17	F 58	4				
	payment for the los mid October.	ss. R254 believed it was lost in						
	missing property in	ealed that there was no expension and there was no of the missing ring entered into hal property log.						
	ring was not include property inventory that there was no invector. She stated to Medical Records it. DSS stated this discussed at the lewas unable to find discussion. DSS in	1/8/19, at 9:25 a.m. that the ed on R254's personal on admission, but she verified enventory included in R254's at the form may have been sent as and indicated she requested. loss would have been adership morning meeting, but any documentation of the dicated R254 would have been em had been listed on the						
		age was left for R254's son on .m.; however, the phone call						
	at 7:36 a.m. and st the missing ring at indicated missing i morning leadership had not been docu property inventory. the policy states th accountability if the signed inventory lis typically a claim of investigated and a made for any item	was interviewed on 11/12/19, ated he was made aware of least a month ago. He tems were reviewed at the meetings and was aware it mented on R254's personal. The administrator indicated e facility would not have eitem had not been on the st. The administrator stated a missing item would be police report would have been valued at \$50 or greater. R254 in admitted and the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 609 SS=D	been contacted to a The administrator a no one had seen the usually contact hose sent with the reside DSS should have to DSS was interviewed a.m. and verified the contacted. The DS personal property in The facility Grievan outlined that missindirected to the DSS included investigatives addressing and rese Reporting of Allege CFR(s): 483.12(c) (1) §483.12(c) (1) Ensure involving abuse, nemistreatment, inclusion with administrator of the administrator of the administrator of the administrator of the seen that cause and do not rethe administrator of the seen that cause the allegative and do not rethe administrator of the seen that cause and do not rethe administrator of the seen that cause the allegative and do not rethe administrator of the seen that cause the seen that cause the administrator of the seen that cause the s	ated the family should have verify the item was missing. also stated he was confident are ring and the facility did not spitals to see if the item was ent. The administrator indicated aken a few more steps. The administrator indicated aken a few more steps. The daministrator indicated aken a few more steps.	F 6			12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		12/2019	
THE CAI	RDENS AT CANNON	EALLS		300 N	ORTH DOW STREET			
THE GAI	NDENS AT CANNON	FALLS		CAN	NON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION FACH CORRECTIVE ACTION SHOULD BE DESS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 609	provides for jurisdic facilities) in accorda established proced §483.12(c)(4) Repoinvestigations to the designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct This REQUIREMED by: Based on observative review, the facility fallegation of mistre (SA) for 1 of 5 resign physical abuse. Findings include: The director of nurs 11/5/19, at 4:57 p.m. 2:30 p.m. she was assistant (NA)-B th (LPN)-A was "rough DON explained NA rough." DON stated when NA-B explain with the administration be reported to the and/or R41 or other that time. DON, the assistant and NA-B were integrited.	e services where state law ction in long-term care ance with State law through ures.	F6	1 th ne pre are in 2. re as at the be grund expression of the pression of the	It is the policy of this facility to enat all residents are free from abuseglect, misappropriation of residence poperty, and exploitation. R41was eviewed to ensure they were free from abuse sported to OHFC and an in-depth evestigation was completed. This has the potential to affect all esidents. All current residents have seesed to ensure they are free frouse, neglect, misappropriation of esident property, and exploitation. Staff have been in-serviced on the cility abuse policy on 12/20/2019. The director of nursing or designed responsible for compliance. Auch ecompleted on all risk management is appropriation of resident proper exploitation of resident proper exploitation of residents has occurred the control of this deficited in the control of the complete exploitation of residents has occurred the control of this deficited in the control of the complete exploitation of residents has occurred the control of this deficited in the control of the contro	from was facility been om f e ee will dits will ent and glect, ty and ed to ency en		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 609	NA-B explained R4 touched and LPN-A handled" R41 as R her. NA-B stated R me alone leave me arms inward, howe indicated LPN-A as changing R41 out oboth LPN-A and NAR41 while "pulling ADON confirmed ther of concerns reg LPN-A to R41. ADO notified DON whom NA-B stated he did rough treatment to	ical" and "rough" with R41. 1 was asking not to be A continued on and "man 41 was "begging not to touch" 41 repeatedly yelled, "leave alone" as R41 tightened her ver LPN-A did not stop. NA-B sked NA-D to assist with of urine soaked clothing and A-D continued "manhandling" her clothes off against her will." hat on 11/2/19, NA-B notified garding "rough" care from DN stated she and NA-B n said it was not reportable. not report the concern of R41 right away due to having at the facility and worried	F	609	recommendation.		
	and verified a report physical abuse was 11/5/19. DON state report any allegation and/or SA within two R41 was interviewed was unable to answard R41's Quarterly Min 8/26/19, identified Fimpairment and dia dementia and Park MDS indicated R41 assistance with act	ed on 11/7/19, at 6:49 a.m. and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER		B: ******		REET ADDRESS, CITY, STATE, ZIP CODE	11/	12/2019	
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THE GARDENS AT CANNON FALLS				C	ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 610 SS=D	The policy indicated free from abuse and condone any form of indicated any individuated any individuated any individuated any individuated any individuated any individuated and instrator, DON incident of resident confirmed the incident of acility managem lapse. The policy furth would report suspending manner to approve timely manner to approve to the policy furth of the second and the sec	by someone to an individual. It residents had the right to be do the facility would not of resident abuse. The policy dual observing an incident of uspecting resident abuse eport such incident to the or change nurse and when an abuse was suspected or ent must have been reported ent regardless of the time rither indicated the facility of the time appropriate agencies. Correct Alleged Violation (2)-(4) Inse to allegations of abuse, in, or mistreatment, the facility evidence that all alleged ughly investigated. Ent further potential abuse, in, or mistreatment while the rogress.		610	1.There was an allegation of abuse		12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		245304	B. WING				12/2019	
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				300 [NORTH DOW STREET			
THE GAR	RDENS AT CANNON	FALLS		CAN	NON FALLS, MN 55009			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	ON	(X5)	
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE	
F 610	Continued From p	page 22	F6	310				
	·	failed to thoroughly investigate			nvolving R41was communicated	to		
		ction following an allegation of			administrative staff on 11/05/201			
		for 1 of 5 residents (R41)			eported to OHFC and an in-dept			
	reviewed for physi				nvestigation followed that include			
				p	placing two staff members on			
	Findings include:				nvestigatory leave and interviewi			
					staff members that worked with t	he		
		rsing (DON) was interviewed on			alleged perpetrators.			
		m. and stated on 11/2/19, at			2.The facility will take the followin			
		s informed by the nursing hat licensed practical nurse			n response to an alleged violatio	n oi		
		gh" with R41 the other night.			abuse, neglect, exploitation or nistreatment: Thoroughly investi	adt ater		
		A-B indicated "he felt likewas			alleged violation that will include			
		ed it did not seem as serious			he alleged perpetrator on investi			
		ned it and after DON talked			eave, complete a through body a			
		ator they decided it did not need			he resident involved. The body a			
	to be investigated	any further. DON indicated		n	may expand to residents in the fa	cility that		
		l or other staff were not			nave dementia. Residents that ar			
		t time. DON further indicated			and oriented will be interviewed r	egarding		
		nteractions between staff and			heir interactions with the alleged			
		observed. Furthermore, DON			perpetrator. The resident involved			
		and/or NA-D were allowed to			nave cares observed. Staff will be			
	remain working to 11/2/19.	llowing the allegation made on			nterviewed to see if they have co hey will be asked to provide a wi			
	11/2/19.				statement. Prevent further abuse			
	DON assistant di	rector of nursing (ADON) and			neglect, exploitation and mistreat			
		ewed on 11/5/19, at 5:06 p.m.			rom occurring while the investiga			
		1/2/19, it was reported to ADON			progress; and take appropriate c			
		gs ago NA-B observed LPN-A			action, as a result of investigation			
		nd "rough" with R41. NA-B			B.All staff have been in serviced			
		s asking not to be touched and		fa	acility policy on investigating any			
		on and "man handled" R41 as			allegation of abuse, neglect,			
	55 5	not to touch" her. NA-B stated			nistreatment, injury of unknown			
		elled "leave me alone leave me			and misappropriation of resident	property		
		ntened her arms inward,			on 12/20/2019 L'The Social convince director er d	oolar		
		licated LPN-A did not stop.			I.The Social service director or d	•		
		PN-A asked NA-D to assist with of urine soaked clothing and			vill be responsible for compliance vill be completed on all OHFC re			
	0 0	IA-D continued "manhandling"			ensure a thorough investigation v			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED C	
		245304	B. WING			ن 1 2/2019	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS				STREET ADDRESS, CITY, STATE, ZIP (300 NORTH DOW STREET CANNON FALLS, MN 55009		12/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 610	Continued From page 23 R41 while "pulling her clothes off against her will." ADON confirmed on 11/2/19, NA-B notified her of concerns regarding "rough" care from LPN-A to R41. ADON stated she and NA-B notified DON whom said no further follow-up was needed.		F 610	completed to prevent reocc deficiency daily x 4 weeks, then monthly x 1. Results w by our Quality committee for recommendation	weekly x 4, vill be reviewed		
	DON was interview and verified the fact allegation of physic NA-D were placed stated it was their elinvestigating and ounit following an all	ved on 11/6/19, at 10:35 a.m. bility began investigating an eal abuse and both LPN-A and on administrative leave. DON expectation to begin bserving cares/ monitoring the legation of physical abuse. ed on 11/7/19, at 6:49 a.m. and					
	8/26/19, identified I impairment and dia dementia and Park MDS indicated R41	nimum Data Set (MDS) dated R41 had severe cognitive agnoses which included inson's disease. The Quarterly I required extensive staff ivities of daily living.					
	9/27/19, indicated a or infliction of harm The policy indicated free from abuse an condone any form indicated any indiviresident abuse or smust immediately radministrator, DON incident of resident confirmed the incident of facility management lapse. The policy in the confirmed the incident of the inci	Policy and Procedure adopted abuse referred to mistreatment by someone to an individual. It residents had the right to be ad the facility would not of resident abuse. The policy dual observing an incident of suspecting resident abuse report such incident to the later of the lat					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS				STREET ADDRESS, CITY, STATE, ZIP COL 300 NORTH DOW STREET CANNON FALLS, MN 55009	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	HOULD BE	(X5) COMPLETION DATE	
F 610	which would include interviews and inter Furthermore, the per the facility whom has	stigation of the alleged incident e witness reports, staff rview other residents. olicy indicated employees of ad been accused of resident spended immediately pending	F 6	10			
F 676 SS=D	Activities Daily Livin CFR(s): 483.24(a)(§483.24(a) Based of assessment of a refresident's needs are provide the necession entry en	ng (ADLs)/Mntn Abilities 1)(b)(1)-(5)(i)-(iii) on the comprehensive esident and consistent with the end choices, the facility must ary care and services to ent's abilities in activities of liminish unless circumstances dinical condition demonstrate in was unavoidable. This ensuring that: sident is given the appropriate ices to maintain or improve his ry out the activities of daily see specified in paragraph (b) es of daily living. evide care and services in aragraph (a) for the following ring: ene -bathing, dressing,	F6	76		12/29/19	
	§483.24(b)(3) Elim	ination-toileting,					

` '		` IDENTIFICATION NUMBER.		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245304	B. WING		C 11/12/2019		
	NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		2/2010	
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 676	Continued From pa §483.24(b)(4) Dinii snacks,	age 25 ng-eating, including meals and	F 676				
	§483.24(b)(5) Com (i) Speech, (ii) Language, (iii) Other functional This REQUIREME by: Based on observate review, the facility assess and ensures services were developed incontinence for 1 able to carry out so Findings include: R35 was observed her call light on. At (NA)-C entered R3 to be lying in bed with from R35's bed. R3 bathroom as NA-C indicated R35 was NA-C indicated R35 was NA-C indicated R35 was wine and needed to R35 to turn onto he wet with urine from the middle of the beading was considered R35 was interviewed stated she had ask around midnight, he whom answered here.	amunication, including all communication systems. NT is not met as evidenced ation, interview and document ailed to comprehensively athe necessary cares and aloped regarding bladder of 1 resident (R35) who was ame of her ADL activities. on 11/7/19, at 7:10 a.m. with 7:19 a.m. nursing assistant 5's room. R35 was observed with a strong urine odor coming 35 requested to go to the removed R35's blanket NA-C lying in a urine soaked bed. 5's "entire bed was "wet" from o be changed. NA-C assisted are side and indicated R35 was the middle of the thighs up to ack. NA-C indicated the urine adding around the edges and old and wet. and on 11/7/19, at 7:35 a.m. and are to go to the bathroom owever indicated the staff are call light turned her call light bond and walked out of the		1.R35 will have a bowel and bladder assessment to identify toileting patt This will be completed by 12/29/20 analysis of the bowel and bladder assessment will be done and a toile program will be scheduled. 2.All current residents have been reviewed for current bowel and blad assessment and reassessed as ne Care plans reviewed and updated treflect current bowel and bladder not This has the potential to affect all faresidents 3.All nursing staff have been in servicenthe facility policy for bowel and bladsessessments by 12/29/2019. All nurstaff will be in serviced on providing necessary care and services. 4.The director of nursing or designed be responsible for compliance. Auch be done weekly x 4 and then month Results will be reviewed by our Quarcommittee for further recommendal.	terns. 19. An eting dder eeded. to eeds. acility viced bladder arsing g ee will dits will hly x 2. ality		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245304	B. WING			C 11/12/2019		
	PROVIDER OR SUPPLIER	FALLS		30	TREET ADDRESS, CITY, STATE, ZIP CODE DO NORTH DOW STREET ANNON FALLS, MN 55009	<u>, 11/</u>	12/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 676	room. R35 stated sindicated it "only ha would not assist R3 NA-C was interview and stated there we when residents wowet, however indicatuncommon. R35 was observed told the administrat had an accident du "she was soaking wheen on the schedudon't lay in bed soa R35's annual Minim 9/26/19, indicated Fimpairment and dia depression and dia MDS indicated R35 with ADLs and did in The MDS further in incontinent or urine R35's care plan revelated to assist for toof bladder, change R35's care plan revelated to need for stasks and use of michange as needed each incontinent epicated to sea to s	he went back to sleep and ppens sometimes" when staff 25 to the bathroom. Wed on 11/7/19, at 7:40 a.m. Pere certain days of the week all be found in bed that were atted wet beds was not at a staff should have all to help people "so that they king wet." The Data Set (MDS) dated 235 had moderate cognitive gnoses which included manic betes mellitus. The annual required extensive assistance not have a toileting program. Dicated R35 was occasionally and bowel. The Data Set (MDS) dated R35 was occasionally and bowel. The annual required extensive assistance not have a toileting program. Dicated R35 was occasionally and bowel. The deficit and directed determined and as needed. Dised 10/10/19, identified R35 well and bladder incontinent when soiled and as needed. Dised 10/10/19, identified R35 well and bladder incontinence staff assistance with toileting edications and directed staff to when soiled, pericare with bisode and monitor for signs rinary tract infection.	F 6	76				

245304 B. WING 11/1) 2/2019
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Assessment dated 10/10/19, identified R35 had long term bowel and bladder incontinence and indicated "care plan to address toileting needs with strategies to meet her needs as staff are able." NA-A was interviewed on 11/8/19, at 7:40 a.m. and stated she found R35 this morning with her "entitre bed is wet" from urine. NA-A stated she told the NA "last night" to assist R35 to the bathroom due to concerns of having been wet, however was unsure what happened. R35 was interviewed on 11/8/19, at 7:45 a.m. and stated she was wet and cold that morning and did not like to be wet. R35 indicated when requested, before midnight, staff had assisted her to the bathroom. The director of nursing (DON) was interviewed on 11/8/19, at 12:01 p.m. and stated it was her expectation to complete a bladder three day assessment and develop the care plan based on when the resident needed to be toileted. DON further stated it was her expectation for staff to assist a resident to the bathroom when requested. The facility Urinary Continence and Incontinence-Assessment and Management policy adopted 8/8/16, indicated as part of ongoing assessment the nursing staff would screen for information related to urinary incontinence which identified relevant information as observations, including wet bed or clothing. The policy indicated staff would provide scheduled toleting, prompted	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING				C 1 2/2019
	NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS			30	TREET ADDRESS, CITY, STATE, ZIP CODE ON NORTH DOW STREET ANNON FALLS, MN 55009		12/2010
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	Continued From paindividualized at nigand skin integrity and ADL Care Provided CFR(s): 483.24(a)(2) A resout activities of daily services to maintain personal and oral hand This REQUIREMENT by: Based on observative review, the facility fassistance for 1 of shower assistance needed assistance (ADLs). In addition, shaving assistance R42) who needed a Findings include: R44 was observed his call light on. At 75 and 56 an	ge 28 Int in order to maintain comfort and minimize sleep disruption. I for Dependent Residents 2) Sident who is unable to carry y living receives the necessary a good nutrition, grooming, and	F 6	377		g daily nd not d d lies are erly, d as	12/29/19
	bed pan as he had At 8:05 a.m. nursing observed to answer R44's room R44 tol "waiting more than to have had a bowe pericares and assis R44 also said to NA"45 minutes" and N as fast as the two of	ed assistance to get off of the "been done for a long time." g assistant (NA)-A was r R44's call light when entering d to NA-A he had been I should." R44 was observed be movement NA-A provided sted R44 off of the bed pan. A-A that he had been waiting A-A replied, "we are working if us can."			preferences. Level of assistance red and bathing preferences will be communicated to direct care staff the PCC and POC. Preferences and level assistance will be reviewed quarterly care conferences and as needed. 2.All current residents have been reviewed for current ADL assessment reassessed as needed. Care plans reviewed and updated to reflect current ADL needs. This has the potential to affect all facility residents. 3.Education will be provided to all needs.	ent and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245304	B. WING			C 11/12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	CIES ID PROVIDER'S PLAN OF CORRECTION BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
F 677	diagnoses which i depression. The quered extensive frequent incontine program. R44's care plan readed had an ADL sand directed staff of staff for the use movements. R44 was interview stated staff when a long time for assactivating his call line. NA-A was interview and confirmed R4 minutes on the be "really far behind" The director of nu 11/8/19, at 1:06 p. staff to respond as	R44 had intact cognition and noluded dementia and manic uarterly MDS indicated R44 e assist with toileting and was not of bowel without a toileting evised on 10/22/19, indicated self-care performance deficit to provide extensive assistance of the bed pan for bowel ed on 11/8/19, at 8:15 a.m. and staff would call in he would wait sistance from staff after ight. Wed on 11/8/19, at 8:20 a.m. 4 was waiting at least 30 dpan. NA-A stated they were getting residents up for the day. Triangle (DON) was interviewed on m. and stated she expected is promptly as they were able.	F 67	staff by 12/29/2019, related care expectations. 4. The director of nursing or be responsible for compliar be done weekly x 4 then m. Results will be reviewed by committee for further reconstitutes.	designee will nce. Audits will onthly x 2. our Quality		
	had intact cognition included anemia, peripheral vascula mellitus. The annu	S dated 10/3/19, identified R43 in and diagnoses which end stage renal disease, ir disease and diabetes all MDS further indicated R43 on and/or oversight with ADLs.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
	245304	B. WING		11	C / 12/2019		
			300 NORTH DOW STREET	•	712/2010		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE		
R43's ADL Care A 10/17/19, identified with ADLs and dire as they were able. R43's care plan re required assistance staff to provide one showers. The care often refuse shower there was not a market amale would show waited an hour and shower and stated staff and asked where was not a market amale would show waited an hour and shower and stated staff and asked when she could be shown as the stated she was the st	rea Assessment dated d R43 needed staff assistance ected staff to meet R43's needs vised 10/23/19, identified R43 e with showering and directed e staff assist with weekly plan indicated R43 would ers when tired and/ or when ale staff available. M)-B was interviewed via (19, at 10:33 a.m. and stated shower in over two weeks. ek ago she "asked the nurse 3 was showered and requested ver R43. FM-B indicated she d nobody came to offer R43 a she then approached a male nen R43 would be showered. aff indicated he was unaware wer and walked away. FM-B ame back to visit R43 two to 43 "still" had not had a shower. xpressed a concern at R43's ce regarding showers not estaff indicated they would look out was reviewed 9/15/19,	F 677	,				
	ROVIDER OR SUPPLIER RIDENS AT CANNON SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From particles and direct as they were able. R43's ADL Care A 10/17/19, identified with ADLs and direct as they were able. R43's care plan re required assistance staff to provide one showers. The care often refuse shower there was not a marked and as they were able. Family member (Fittlephone on 11/5/R43 had not had a FM-B stated a weed please" ensure R4 a male would show waited an hour and shower and stated staff and asked when she continued and the staff and stated she elast care conference completed and the into it. R43's Bathing Repart of the continued and the into it.	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 30 R43's ADL Care Area Assessment dated 10/17/19, identified R43 needed staff assistance with ADLs and directed staff to meet R43's needs as they were able. R43's care plan revised 10/23/19, identified R43 required assistance with showering and directed staff to provide one staff assist with weekly showers. The care plan indicated R43 would often refuse showers when tired and/ or when there was not a male staff available. Family member (FM)-B was interviewed via telephone on 11/5/19, at 10:33 a.m. and stated R43 had not had a shower in over two weeks. FM-B stated a week ago she "asked the nurse please" ensure R43 was showered and requested a male would shower R43. FM-B indicated she waited an hour and nobody came to offer R43 a shower and stated she then approached a male staff and asked when R43 would be showered. FM-B stated the staff indicated he was unaware R43 needed a shower and walked away. FM-B stated when she came back to visit R43 two to three days later R43 "still" had not had a shower. FM-B stated she expressed a concern at R43's last care conference regarding showers not completed and the staff indicated they would look into it. R43's Bathing Report was reviewed 9/15/19, through 11/7/19, and directed staff to shower R43	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 30 R43's ADL Care Area Assessment dated 10/17/19, identified R43 needed staff assistance with ADLs and directed staff to meet R43's needs as they were able. R43's care plan revised 10/23/19, identified R43 required assistance with showering and directed staff to provide one staff assist with weekly showers. The care plan indicated R43 would often refuse showers when tired and/ or when there was not a male staff available. Family member (FM)-B was interviewed via telephone on 11/5/19, at 10:33 a.m. and stated R43 had not had a shower in over two weeks. FM-B stated a week ago she "asked the nurse please" ensure R43 was showered and requested a male would shower R43. FM-B indicated she waited an hour and nobody came to offer R43 a shower and stated she then approached a male staff and asked when R43 would be showered. FM-B stated the staff indicated he was unaware R43 needed a shower and walked away. FM-B stated when she came back to visit R43 two to three days later R43 "still" had not had a shower. FM-B stated she expressed a concern at R43's last care conference regarding showers not completed and the staff indicated they would look into it. R43's Bathing Report was reviewed 9/15/19,	ROVIDER OR SUPPLIER ### STREET ADDRESS, CITY, STATE, ZIP CC ### SUMMARY STATEMENT OF DEFICIENCIES ### (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### CROSS-REFERENCY CONTinued From page 30 R43's ADL Care Area Assessment dated ### 10/17/19, identified R43 needed staff assistance ### with ADLs and directed staff to meet R43's needs ### ass they were able. ### R43's care plan revised 10/23/19, identified R43 required assistance with showering and directed ### state on 11/5/19, at 10:33 a.m. and stated ### R43 had not had a shower in over two weeks. ### FM Stated a week ago she "asked the nurse ### please" ensure R43 was showered and requested a male would shower R43. FM-B indicated she ### waited an hour and nobody came to offer R43 a ### shower and stated she then approached a male ### stated the staff indicated he was unaware ### R43 needed a shower and walked away. FM-B ### stated the staff indicated he was unaware ### R43 needed a shower and walked away. FM-B ### stated when she came back to visit R43 two to ### three transports to the received and requested and the staff indicated he was unaware ### R43 needed a shower and walked away. FM-B ### stated when she came back to visit R43 two to ### three transports to the received and requested and the staff indicated they would look into it. ### R43's Bathing Report was reviewed 9/15/19, ### through 11/7/19, and directed staff to shower R43.	FORRECTION DENTIFICATION NUMBER: 245304 B. WING		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245304	B. WING _		11	/ 12/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 677	Applicable;" -On 10/13/19, the interpretation of the process of th	report indicated bathing "Not report indicated independent report indicated bathing "Not survey began), the report e assist with bathing. ed on 11/6/19, at 8:32 a.m. and shower." R43 was observed to y quarter inch long finger nails lerneath the nail, dirty clothing them, and R43 was stated he had not had a shower and when he had requested no	F 67	7		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245304	B. WING			C / 12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009		112/2010	
(X4) ID PREFIX TAG			ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 677		age 32 arding bathing was requested,	F 6	777			
	severe cognitive im extensive assistand perform personal h included Alzheimer behaviors, weakne	rterly MDS identified R29 had apairment. R29 required ce of one staff to dress and aygiene. R29's diagnoses 's disease, dementia with ss, degenerative joint disease, lled movement), and history of					
	cognitive loss, limit weakness. R29 was trisk for a great required extens dress and perform unable to commun anticipate and mee aggressive behavior diagnosis of dehyd and assist R29 with intake, and provide R2 was at risk for a great risk for a	entified R29 had dementia with ed physical mobility, and as unable to provide self-care. sive assistance of 1 staff to personal hygiene. R29 was icate needs. Staff were to et R29's needs. R29 had or with cares. R29 had a recent ration. Staff were to supervise in meals, encourage fluid a nosey cup for fluid intake. aspiration and had problems ing while eating and drinking.					
	R29 required exter perform personal h with supervision. R to ensure staff cou during meals. Staff	rent NA care sheet included asive assistance of two staff to bygiene. R29 was to eat only 29 ate in the small dining room ld observe him at all times were to offer fluids throughout nosey cup for liquids.					
		4/19, of R29 at 10:37 a.m. eared unshaven, and debris ls.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
245304			B. WING		11/12/2019		
	PROVIDER OR SUPPLIER	FALLS		300	EET ADDRESS, CITY, STATE, ZIP CODE NORTH DOW STREET INON FALLS, MN 55009		
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Observation on 11/ the hallway by the r patchy with long fac lower lip chin. Observation on 11/ lying on the right sic remained unshaver on his on upper and face. Observation on 11/ his wheelchair at th unshaven. License handed R29 a 4 ou a straw and cued h drink the suppleme cart and resumed p pushed the cart aw R29 sat and entere without providing R the supplement. R2 supplement through Interview on 11/7/1 stated he was unaw drink with a straw, not looked at R29's	07/19, at 7:32 a.m. R29 sat in nurse desk. R29's face was cial hair under his nose on 06/19, at 11:56 a.m. R29 was de in bed with oxygen on. R29 in with white facial hair visible d lower lip and left side of his 07/19 at 1:15 p.m. R29 was in the nurse station. R29 remained and practical nurse (LPN)-E ince glass of supplement with im to drink it. R42 stated to int. LPN-E turned toward the passing medications. LPN-E and exited other rooms 29 supervision while drinking 29 continued to drink the in the straw until gone. 9, at 1:15 p.m. with LPN-E ware R29 was not supposed to LPN-E acknowledged he had a care plan prior to providing k the supplement. LPN-E	F 6	77	DEFICIENCY)		
	R29 was not to drin Interview on 11/07/ identified she was a unshaven face. Sta shave him but his r	verified it did not indicated ak with a straw. 19, at 2:54 p.m. with DON aware of R29's unkempt of reported they attempted to azor blades were dull. Two ontacted R29's guardian to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTI		(X3) DATE SURVEY COMPLETED C		
		245304	B. WING			11/12/2019	
	PROVIDER OR SUPPLIER	FALLS		300 NORTI	DDRESS, CITY, STATE, ZIP CODE H DOW STREET FALLS, MN 55009	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT EACH CORRECTIVE ACTION SHOU DSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 677	new, and unable to purchase new bladhad no razor blades meantime. DON stacups for R29 and pand fluid intake. Th DON expected staff Interview on 11/08/therapist (ST)-A veand supervision to staff to not use straswallowing well follocondition and was a where fluids had the and lungs. The only aspiration was by p study. R29 was to uhad been canceled hospice. ST-A was was appropriate with	r blades. R29's guardian was access R29's money to es until recently. The facility of for R29 to use in the ated staff were to use nosey rovide supervision with meals e care plan stated no straws. If to follow R29's care plan. 19, at 11:49 a.m. speech rified R29 required assistance eat and drink. ST-A instructed was because R29 was not owing a recent change in at risk for silent aspiration e potential to enter his airway way to diagnose silent erforming a video swallow undergo testing, however that due to R29's admission to a unable to verify if straw use thout a video swallow study. In a video swallow study. In a video swallow study.	F6	77			
	cognition was intact depression, but felt several days per wand no behaviors. In included extensive transfer. R42 requires staff for bed mobility unit, and with personal staff.						
		l interview with R42 on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245304	B. WING		1	C 11/12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET CANNON FALLS, MN 55009		1712/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	CTIVE ACTION SHOULD BE COMPLÉTIO DATE		
F 677	bed. R42's bed was clothing had cruml oxygen. R42's factovered his face, and was unable to razor he had recer R42 was "fed up where because they reported his concernurses, and DON never heard back asking for it. R42 bathe, use the bat R42 also required his wheelchair as occasions R42 ast to his room. Staff thand frequently refuroom. R42 frequer hour for assistance light to get help. Observations from 11/07/19, at 7:41 as be unshaven. Observation and in p.m. NA-C stated sliquid oxygen canis She was unsure if but usually saw him assisted R42 to his unsure if any other R42 was able to prom the dining roor required help to get linterview on 11/07/19.	age 35 as at floor level. R42's bed and be on it. He was wearing sal hair was ½ inch long, and R42 was not growing a beard shave because the electric ontly purchased was missing. with how they do things around a [staff] don't listen". R42 erns and notified nurse aids, about his missing razor and from anyone. R42 gave up required assistance to shave, throom and perform daily care. assistance with ambulation in the tired easily. On several ked for assistance to get back hold R42 could push himself used to help him back to his ontly waited for over one-half e when he activated his call a 11/04/19, at 6:41 p.m. through a.m. identified R42 continued to the needed oxygen at all times, more wearing it. NA-C had not a restaff assisted him to his room. The health has sized him to his room. The hallways on, and was unsure if he to and from the dining room.	F 6	77			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING			2/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 679 SS=D	his razor was missing rievance because razor was not missing what was wrong wilke this. DON verification was taff find his reday. At 3:20 p.m. new razor in his bustand. DON verification and had not strated them to, now. A policy and proces of care or providing policy was provided Activities Meet Interest CFR(s): 483.24(c)(1) The the comprehensive and the preference program to support activities, both facili individual activities designed to meet to physical, mental, and each resident, encound interaction in the This REQUIREME by:	DN was aware R42 reported ing, but did not complete a he was a hoarder, and his ing. DON stated was not sure th R42, because he was never ied she had requested staff to e on Tuesday, and she would azor and assist him to shave DON reported staff found his cket in his room on the night d staff had not looked for the shaven R42 after she but they were assisting him dure was requested for quality activities of daily living. No d. rest/Needs Each Resident 1) Is. facility must provide, based on assessment and care plan is of each resident, an ongoing a residents in their choice of ity-sponsored group and and independent activities, the interests of and support the ind psychosocial well-being of ouraging both independence	F 67			12/29/19	
	centered, meaning	ailed to provide person ful activities which included the facility for 1 of 3 residents		residents have meaningful activities participate in. R43 interest in activition was reviewed by the activity director	es		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING				C 12/2019	
	PROVIDER OR SUPPLIER	FALLS		30	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH DOW STREET ANNON FALLS, MN 55009	<u>, , , , , , , , , , , , , , , , , , , </u>	12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 679	(R43) reviewed for Findings include: R43 was interviewed stated he was unable shopping activity durings outside of the which conflicted with R43 indicated it was person item shopping been a younger math is mother always of shopping. R43 state nursing (DON) and about his desire to activity, however not occurred. R43's annual Minimal 10/3/19, identified for diagnoses which in renal disease, periguiabetes mellitus. The indicated it was "vertavorite activities. R43's care plan reversal reversal reversal for social time, participation in R43's family to atte support participation types and locations daily schedule and	activities. ad on 11/4/19, at 6:55 p.m. and ble to attend the monthly be to the facility scheduling the he facility on Wednesdays th R43's dialysis schedule. It is important for him to going for himself due to having an and not wanting staff and/or doing his personal item be the activities director (AD) participate in a shopping of changes and/or follow-up to the activities director (AD) participate in a shopping of changes and/or follow-up to the activities director (AD) participate in a shopping of changes and/or follow-up to the activities director (AB) to the activities and stage of the annual MDS further the annual MDS further the facility to participate in the staff to explain to R43 the all interaction, leisure activity in activities, invite/encourage and activities with R43 to in, offer a variety of activity to maintain interests, modify	F 6	79	ensure we were meeting the needs R43. 2. This has the potential to affect all residents in the facility. All current residents activities interest will be reviewed and updated as needed to 12/29/2019. 3. The activity director and activity swere in serviced on 12/18/2019 on facility policy of meaningful activities residents. 4. The activity director or designed audit to ensure all residents are participating in meaningful activities ensure compliance. Audits will be completed weekly x 4 then monthly Results will be reviewed by our Quicommittee for further recommendations.	estaff the es for will s to / x 2. ality		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _		11	/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 679	10/2/19, indicated and participation leblank, no interventineeded for R43 to plan remained curr were met and inter R43's Activity Sche 8/2019, through 10 following: -R43's 8/2019, sch participated in goin and/or movies and however lacked ev-R43's 9/2019, sch participated in one daily going outdoor-R43's 10/2019, sch participated in going games/activity, how facility outing, how outing. AD was interviewed verified R43 had no outside of the facility or a senior golf ca attended a baseba	cipation Review effective R43's attendance preferences vel with activities was left ons and/ or adaptations participate in programs, care ent and appropriate, goals ventions remained effective. Edule was reviewed from 1/31/19, and revealed the edule indicated R43 goutdoors, watching TV physical games/activity daily, idence of facility outing; edule indicated R43 facility outing on 9/19/19, and is and physical games/ activity; hedule indicated R43 goutdoors daily and physical vever lacked evidence of ever lacked evidence of ever lacked evidence of facility outing at 10:03 a.m. and of participated in an activity ty since 9/2019, when he went rt ride and in 7/2019, when he ll game. AD stated R43	F 67	9			
	patio and visit with facility offered shop Wednesdays, how due to R43's dialys was aware R43 "m the facility shopping the facility, however worked best for the	ide daily to smoke on the front peers. AD confirmed the oping activities on ever R43 was unable to attend is schedule. AD stated she entioned" he wanted to out of g and/or to activities outside of a AD stated Wednesdays e activities department due to explained she had not					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	COM	COMPLETED	
		245304	B. WING _			C / 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		12/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684 SS=D	attempted to offer a outside of the facilit Thursdays staffing accommodate this. DON was interview and stated it was he try their best to mal residents were able DON explained R4: outside of the facilit R43's dialysis had to R43 could attend. The facility activity provided. Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a rethat residents received accordance with propractice, the compression care plan, and the of the treatment of the compression of the c	an alternate day for activities by, however identified would be able to ed on 11/8/19, at 12:11 p.m. er expectation for the facility to be accommodations so all eto participate in activities. When we are subject to attend an activity by over the summer, however to be rearranged to ensure policy was requested, but not care fundamental principle that then and care provided to assed on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of rehensive person-centered	F 68	79	aring for	12/29/19
	review, the facility f of 1 resident (R44) chest pain, and req Emergency Room facility failed to perf	ailed to promptly respond to 1 report of shortness of breath, uest to be transported to an for evaluation. In addition, the form leg treatments for 1 of 1 duled for daily leg wraps for		residents in a competent and d manner to include honoring recohoices related to their care. Retransferred to the emergency d on 11/07/2019 at 12:57 p.m. af complaining of chest pain, show breath and wheezing. He return	ignified luests and 44 was epartment ter tness of	

PRINTED: 12/23/2019 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA (X2		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245304	B. WING			C		
NAME OF PROVIDER OR SUPPLIER	245304	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	11/1	2/2019	
THE GARDENS AT CANNON FA	ALLS		30	00 NORTH DOW STREET ANNON FALLS, MN 55009			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
included diagnoses of hypoxemia, and urina 10/29/19. R44 also he disorder, Major Deprodisorder, restlessness with behavioral disturblower back pain and extremities, pancreathistory of pulmonary deep vein thrombosis R44's quarterly Minin 10/7/19, identified R4 moderate depression verbally aggressive to care on a daily basis assistance of one starequired extensive as transfer and toilet ansetup for eating. R44 frequently and receive medications. R44 had five feet seven inche pounds. R44 used an and diuretic medications. R44 used a full two staff to transfer. during meals and safe R44 had verbally abused.	port printed on 11/7/19, of sepsis, pneumonia, ary tract infection (UTI) on had diagnoses of bipolar ression Disorder, anxiety as and agitation, dementia rbance, obesity, neuropathy, neuropathy of the lower tic and splenic cysts, and a embolism, lower extremity s, and UTIs. mum Data Sheet (MDS) on 44's cognition was intact, had n, was delusional and owards others, and rejected. R44 required extensive aff for bed mobility, He ssistance of two staff to d required supervision and 4 had pain rated 5/10 yed scheduled pain d severe obesity and was as tall and weighed 272 entipsychotic, antidepressant, ions. tified R44 required aff to turn and reposition in body lift and assistance of R44 required supervision tin the assisted dining room.	Fé	684	hours later with no new orders. On 11/26/2019, R44 was transferred to Clinic St. Mary st. Hospital and had extensive workup. He returned on 12/3/2019. R44 signed onto hospid 12/12/2019. R7 was interviewed or preferences related to application compression devices. The treatme scheduled based on resident prefe All resident will be interviewed b 12/29/2019 to ensure a person-cer approach is in place and choices a honored. 2. This has the potential to affect all residents 3. Education will be provided to all residents 3. Education will be provided to Chan Resident Condition or Status po Accommodation of Needs policy ar Self Determination and Participatio policy. 4. The director of nursing or designed be responsible for compliance. Auc be completed daily x 4 weeks then monthly x 2. Results will be reviewed our Quality committee for further recommendation	e on of of ont was rence. y otered re facility ourses ge in licy, od the on		

cares, allowed time to process information. R44

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _		11	/ 12/2019	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009		<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	had impaired thougwere to keep cons as much as possib many choices as pinclude intervention hospitalization for pand interventions was of antibiotic tree. On 10/29/19, R44's identified on 10/26 hospital through the diagnosed with problem that the problem of the temperature spobtained. A urine of R44 received IV aron 10/29/19, included a non 10/29/19, included a non 10/29/19, included a needed with cares oxygen saturation, and therapy particities on the resident fall, and the call light of the	ght processes. Interventions istent routines and caregivers lie, and provide R44 with as lossible. The care plan did not not to address recent coneumonia, UTI and sepsis, were not included for continued eatment. Is hospital discharge note 1/19, R44 was admitted to the e ED for hypoxemia and was eumonia. Later the same day liked and blood cultures were eulture identified a UTI, and notibiotics. The physician orders led Augmentin 875-125 mg 1 for 10 days; and Levaquin e morning for pneumonia for 9 ediation administration record for a for 10 days; and signs with lung sounds, pain, behaviors, pation. The order was	F 68	4			

I '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _		11	/ 12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	R44's oxygen satu R44 oxygen was noxygen level was noxygen satured in ot contact the he frequently component pain, and half is vital signs were and his oxygen sature limits. She passed oncoming nurse during observation was seated in the oxygen sature of the social worker (SW stated good morning was fine, and decline was noxygen sature of the social worker (SW stated good morning was fine, and decline was noxygen sature of the social worker (SW stated good morning nurse decline was fine, and decline was noxygen sature of the social worker (SW stated good morning nurse decline was fine, and decline noxygen sature of the social worker (SW stated good morning nurse decline noxygen sature of the social worker (SW stated good morning nurse decline noxygen sature of the social worker (SW stated good morning nurse decline noxygen sature of the social worker (SW stated good morning nurse decline noxygen sature of the social worker (SW stated good morning nurse decline nurse noxygen sature of the social worker (SW stated good morning nurse decline nurse nu	ration was 94%. LPN-B told of an option because his normal, and starting oxygen al. She told him she observed respiratory distress and was ok. R44's lungs were een since retuning from the ntly received antibiotics. LPN-B physician or the DON because plained of shortness of breath, d requested to go the hospital. The normal of the normal of the properties of the dining change of shift report. If on 11/7/19 a 8:31 a.m. R44 dining room eating breakfast. In on 44 ortness of breath, and had not of the normal of the properties of the stated he ned to be interviewed. R44 ortness of breath, and had not	F 68	34			
	resident was obser	15 p.m., an unidentified ved being transported on a 00 wing by an ambulance					
	was transported to (ED) at 12:57 p.m. pain, shortness of sounds. He request oxygen was at 94% pain during the nig morning, he went to complain of any sy	the emergency department following complaints of chest breath and wheezy lung sted to go to the ED. His 6. He complained of chest ht. When he woke up the o the dining room and did not mptoms. During breakfast, he feeling well but wanted to finish					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245304	B. WING		1	C 1/12/2019
	NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 43 eating. After breakfast, staff laid him down, and toileted him. His his vital signs were checked. was given a nebulizer treatment at 10:48 a.m. which was ineffective. She notified the DON, a he was transferred to the ED to further evaluat his symptoms. He had complained of all of the symptoms through the current course of his illness, and was taking Levaquin and Augment following his hospitalization for pneumonia. Expiratory wheezes were always present. Review of R44's Weights and Vitals Summary identified the last vitals signs measured taken 11/5/19 at 3:05 p.m Review of R44's progress notes on 11/6/19 an 11/7/19 did not include documentation of R44's reports of chest pain, wheezy lung sounds, request for oxygen, or request to go to the hospital. During interview on 11/8/19 at 10:50 a.m. LPN identified R44 returned from the ED yesterday			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		1/12/2010
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	eating. After break toileted him. His his was given a nebuli which was ineffectine was transferred his symptoms. He symptoms through illness, and was tal following his hospit Expiratory wheezes. Review of R44's Widentified the last v 11/5/19 at 3:05 p.m. Review of R44's pr 11/7/19 did not increports of chest parequest for oxygen hospital. During interview or identified R44 return 11/7/19 after a few and no new orders. On 11/8/19, at 1:53 (DON) was notified and instructed LPN was not aware R44 shortness of breath expected staff to on the hospital as soo chest pain and sho seen by MD Tuesd increased his nebulistory of shortness bypass. Since his	fast, staff laid him down, and so vital signs were checked. He zer treatment at 10:48 a.m. ve. She notified the DON, and to the ED to further evaluate had complained of all of these the current course of his king Levaquin and Augmentin calization for pneumonia. So were always present. Teights and Vitals Summary itals signs measured taken on h Togress notes on 11/6/19 and ude documentation of R44's in, wheezy lung sounds, or request to go to the	F 6	84		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
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F 684	The physician was pneumonia along washortness of breath DON when he had call her and the physical her as ignificant to treatment center, as ignificant physical her a	worried about aspiration with the weigh gain and h. Staff normally called the issues. She expected staff to ysician any time changes in if a nurse had any questions ling a resident's condition. It from 11/7/19, was requested p.m. following an interview if not received for review. In a Resident's Condition or ate), indicated the nurse ge nurse was to notify the group physician of changes in condition when there has change in the resident's mental status and if there was the resident to a hospital or or if a physician provided notified of changes in a n. Except in emergencies, expected to be made within 24 occurring in a resident's andition or status. The charge and to document information dent's physical or mental sident's medical record.	F 68	34			
	in his wheelchair (whe had to wait for helegs wrapped and staff transferred him R7 stated he asked legs at this time but	on 11/4/19, at 6:55 p.m. sitting w/c) near front desk. R7 stated nelp in the mornings to get his get washed up. R7 stated night m to his w/c at about 5 a.m d the night nurse to wrap his at the night nurse had told him he was too busy and the day					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _		11	/ 12/2019	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009				
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F 684	Continued From pa	age 45	F 68	4			
	wanted his legs wr because his physic for his leg wound for getting up and the R7's Annual MDS cognition was intact diabetes and anxie R7 needed extension dressing and with a MDS indicated R7 R7's careplan date have compression legs applied in the	rap his legs. R7 stated he apped when he got up sian had told him it was better or his legs to be wrapped when wound would heal faster. dated 8/1/19, indicated R7's set and included a diagnosis of sty. R7's Annual MDS indicated ive staff assistance with all activities of daily living. R7's did not reject cares. d 6/27/19, indicated R7 was to devices applied to both lower morning and taken off at splan indicated R7 had a solower right leg.					
	was to have "Com	er dated 11/7/19, indicated R7 pression devices to bilateral applied daily related to elling of fluid).					
	been wrapped that wound assessmen	19, at 10:23 a.m. his legs had morning at 8 a.m. because of t completed every Wednesday. ed his legs wrapped when he ng.					
	in his w/c in his roo waiting for his call the nurse had not y his legs should be stated he had to go waiting for 10-15 m minutes later regis	on 11/7/19, at 8:07 a.m. sitting om with his legs unwrapped, light to be answered. R7 stated yet wrapped his legs and stated wrapped when he got up, and to the toilet and had been ninutes already. Couple tered nurse (RN)-A walked into yed R7 what he wanted R7 told					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
245304 B. WING	11/12/2019	
NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD PREFIX (EACH CO	LD BE COMPLÉTION	
F 684 Continued From page 46 RN-A he needed to go to the toilet. R7 was observed on 11/7/19, at 1:33 p.m. legs wrapped. R7 stated licensed practical nurse (LPN)-D had wrapped his legs this morning at 10:15 a.m. R7 stated he had wanted his legs wrapped when the night staff got him up, but the night staff would not, and stated the physician had told him the more he wears the wraps his wounds will go away. RN-A who was also nurse manager stated on 11/7/19, at 1:37 p.m. R7 could have his leg wraps put on at 5 a.m. each day and stated she would change it on the treatment administration record so night shift would do it at 5 a.m. instead of day shift. RN-A stated she would talk to R7 about the time change. R7 was observed on 11/8/19, at 9:55 a.m. sitting in his w/c with his legs not wrapped. R7 stated he had asked the night nurse to do it and the day nurse to do it earlier but it had not happened. R7 stated, "It is not good" lifting up his right pant leg to show surveyor a telpha pad with drainage on a pad on R7's lower left unwrapped leg. R7 stated he had been up in w/c since 4:30 a.m. this morning and nurses had not applied leg wraps. R7 stated his physician had told him the wraps were to be on as soon as he gets up for the day. Licensed practical nurse (LPN)-E stated of day nurse. LPN-E stated LPN-B (night nurse) had reported to him this morning that she had not wrapped R7's legs because she had not noticed		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C	
		245304	B. WING		11	/12/2019	
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F 684	RN-A, nurse mana p.m. she was not a not wrapped R7's I night nurse should the time "yesterday at 5 a.m R7 was observed on the hawrapped. R7 stated won't do it now." LPN-E stated on 1 not wrapped R7's I wrapping R7's legs dressing change on NA-J stated on 11/went to a medical a 8:30 a.m. and stated today. NA-J stated wrapped when he at 8:30 a.m. R7 was observed on his root stated he had gotte appointment at noon nurse had told him legs. R7's care plan date have compression	oday as was not time as was a ed to pass the medications first. ger stated on 11/8/19, at 12:47 the ed to pass the medications first. ger stated on 11/8/19, at 12:47 the ed that the night nurse had egs last night and stated the have since RN-A had changed y" for R7's legs to be wrapped on 11/8/19, at 12:58 p.m. sitting llway with his legs not d, "They (nurses) probably 1/8/19, at 12:59 p.m. he had egs today and was planning on after he completed the		84			
		plan indicated R7 had a					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	COMPLETED		
		245304	B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	1 11/	12/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Director of Nursing 1:02 p.m. R7 was of neurologist for right nurses should follow follow resident care should have prefered. Facility policy According 7/25/16, indicated, should assist reside achieving independ well-being and according independed and preferent facility policy Self Exparticipation dated resident should be with times of days for Treatment/Svcs to CFR(s): 483.25(b)(1) President, the facility (i) A resident receive professional standard pressure ulcers and ulcers unless the indemonstrates that the facility A resident with president with pre	(DON) stated on 11/8/19, at liabetic and was seeing a side numbness. DON stated worders and staff should plans. DON stated residents ences and choices honored. Immodation of Needs dated facility's staff behaviors ent in maintaining and/or lent functioning, dignity and ommodate residents' individual nees. Determination and 7/25/16, indicated each allowed to choose schedules for treatments. Prevent/Heal Pressure Ulcer 1)(i)(iii) egrity sure ulcers. prehensive assessment of a	F 6	DEFICIENCY) 84	RIATE	12/29/19
	with professional st promote healing, pr new ulcers from de	andards of practice, to revent infection and prevent				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD				
		245304	B. WING	i			12/2019
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
THE OAR	DENG AT CANNON	541.0		3	800 NORTH DOW STREET		
THE GAR	RDENS AT CANNON	FALLS		C	CANNON FALLS, MN 55009		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 686	Continued From pa	age 49	' Г (386			
	·	tion, interview and document			1.R43⊟s wounds have been		
		ailed to ensure ongoing			comprehensively assessed by a		
		ehensive assessment, and			registered nurse and care plan upd	ated.	
		nterventions to promote			Resident has been interviewed and		
	healing of a facility	acquired right and left stump			preferences for the day of the week	(for	
	pressure ulcers for	1 of 2 residents (R43)			assessments and time of day for		
	reviewed for pressu	ure ulcers.			treatments has been identified in th		
					plan. Risk and benefits of having w		
	Finding include:				comprehensively assessed weekly	has	
	D401	Data Cat (MDC) Late I			been communicated to R43.		
		num Data Set (MDS) dated			2.All residents identified as high ris		
		R43 had intact cognition and I anemia, end stage renal			pressure development had a new E Scale and their care plan was revie		
		vascular disease and			and updated with interventions as r		
		The annual MDS indicated R43			On admission, any resident noted v		
		le (not stage able due to			pressure wound will be assessed a		
		bed by slough and/or eschar)			wound data collection will be initiate		
		e MDS identified R43 was at			3.Education has been provided to		
	risk of developing p				registered nurse manager regardin		
		led nutrition or hydration,			weekly wound assessments, reside		
		e, applications of ointments/			preferences and the need to docum		
		han to feet. The MDS further			risk and benefits of non-compliance		
		ired supervision and/or			these areas. All nursing staff will be		
	oversight with activ	illes of daily living.			educated by 12/29/2019, on expect of wound care, refusal of care and	alions	
	P/3's Progress No	tes (PN) and Weekly Wound			identification of skin breakdown. Th		
		A) were reviewed from			Pressure Ulcer Risk Assessment p		
		11/6/19, and revealed the			will be reviewed with nursing staff.	Olloy	
	following:	, , , , , , , , , , , , , , , , , ,			4. The director of nursing or designed	e will	
		0/16/19, indicated R43 had			be responsible for compliance. Auc		
	pressure area to th	e front of right "lower leg"			be completed weekly x 4 then mon		
		s a new area, however R43			2, will be done to ensure weekly wo	ound	
	,	R43's care plan was not			assessments include staging,		
		d. A subsequent WWA dated			measurements, treatment plan and		
		R43 had a pressure area to			plan updates are done. Communic		
		ver leg" wound was previously			to physician and resident/family will		
		ed related to artificial legs use,			audited weekly x 4 then monthly x 2		
		A identify "no" R43's care plan or updated. An additional WWA			Results will be reviewed by our Quacommittee for further recommenda		
	was not reviewed 0	n upuateu. An auullionai WWA				uui.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		245304	B. WING			C / 12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF 300 NORTH DOW STREET CANNON FALLS, MN 55009		712/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 686	pressure area to the which was noted at WWA identify "no reviewed or updat 10/16/19, indicate behind of R43 left improvement. Fur 10/16/19, indicate area behind of R4 improvement; The PN dated 10 approached before complete wound a stumps and indicated gegs on, and would assessment; The PN dated 10 getting ready to go requested Register bilateral stumps a legs on. "Bilateral area to right lower redness. Areas be serous crust, no dinflammation. Smalove knee. Skin bordered dressing behind left knee." evidences of mea current intervention—The PN dated 10 seated in the whee was approached findicated R43 decoprior to leaving for again; The PN dated 10 regain; The PN dated 10 regain; The PN dated 10 regain;	dicated R43 had a second he front of the left "lower leg" as a new area, however R43 " R43's care plan was not ed. Additionally, WWA dated d R43 had a pressure area knee which had noted thermore, WWA dated d R43 had a second pressure 3 left knee which had noted d R43 had a second pressure 3 left knee which had noted d R43 had a second pressure 3 left knee which had noted d R43 had both of his artificial d not take them off for an decorated R43 was a to dialysis, floor nurse ared Nurse (RN)-A to "observe" as R43 did not have his artificial stumps observed. Pressure a front leg intact, blanchable whind left knee covered with rainage, erythema or all open area to top of left leg prep applied, adhesive foam applied to right lower leg and However, the PN lack surement and evaluation of	F6	686			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245304	B. WING		11	C / 12/2019
	THE GARDENS AT CANNON FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 51 Thursday, however, the PN indicated R43 "wa outside every time staff wanted to do Tx [treatment];" -The PN dated on 11/6/19, indicated R43 refu observation of both of the stumps, due to R43 had both of his artificial legs on and did not wate to take them off. The PN indicated R43 said "are fine and don't need anything anymore." R43's medical record was further reviewed an lacked evidence of weekly wound monitoring include measurements, evaluations of interventions, and consistent treatments to promote healing of the wound. In addition, R4 medical record lack evidence of risk and benediscussed with R43 regarding refusal of wount treatment and assessment. R43's care plan date initiated on 9/27/19, indicated R43 was at risk for skin breakdown directed staff to administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing weekly every Wednesday, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the doctor, current wound treatme was on Wednesday and Sunday: apply skin p and cover with adhesive foam dressing. Howe R43 care plan lack evidences of R43 preferer regarding wound assessment and treatment. addition, R43 care plan lacked direction to sta			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		712/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINT DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 686	Thursday, however outside every time [treatment];" -The PN dated on observation of both had both of his artit to take them off. Thare fine and don't not are fine and record lacked evidence of include measurement interventions, and opposite are plan day discussed with R43 treatment and asset and monitor for effect assess/record/moneyery Wednesday, depth where possit status of wound penealing progress, redeclines to the doc was on Wednesday and cover with adh R43 care plan lack regarding wound as addition, R43 care	t, the PN indicated R43 "was staff wanted to do Tx 11/6/19, indicated R43 refused of the stumps, due to R43 ficial legs on and did not want ne PN indicated R43 said "they need anything anymore." and was further reviewed and weekly wound monitoring to ents, evaluations of consistent treatments to the wound. In addition, R43 are evidence of risk and benefit a regarding refusal of wound essment. It initiated on 9/27/19, at risk for skin breakdown and minister treatments as ordered ectiveness, itor wound healing weekly measure length, width and ole, assess and document rimeter, wound bed and eport improvements and tor, current wound treatment y and Sunday: apply skin prepesive foam dressing. However, evidences of R43 preference ssessment and treatment. In	F6	86		
	(CAA) dated 10/17	ers Care Area Assessment /19, identified R43 had an ure ulcers and bilateral lower				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245304	B. WING _		11	C / 12/2019		
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COL 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	712/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 686	extremities amputa with medical recomdirected staff to assocks, insulin manarificial legs. R43 was interviewed and stated staff us however indicated wound recently. R4 wound care, however completed prior to for the day. RN-A was interviewed and stated R43 wo supposed to be dorefused. RN-A state and often refused wound assessment. RN-A was observed while doing dressing assessed the wourd measured 0.5 cent described as "super that R43 right stumd dressing on at all time wound was not cover cover and the cover be described as "super that R43 right stumd dressing on at all time wound was not cover and the cover be described as "super that R43 right stumd dressing on at all time described "no dept very light pink." RN additional pressures.	ation and was non-compliance immendations. The CAA sist with placement of shrinker agement and ambulation with add on 11/07/19, at 8:31 a.m. ually put the dressing on, the staff had not observed his a stated he would not refuse ver preferred wound care was putting both artificial legs on wed on 11/07/19, at 8:41 a.m. und assessment was ne daily however R43 often add R43 was "very resistance to take artificial legs off for t. Id on 11/07/19, at 9:11 a.m. ag change for R43. RN-A and on R43's right stump which imeters (cm) by 1.2 cm and artificial, dry." RN-A confirmed ap was supposed to have had a mes, however, verified R43 asured 1.5 cm by 1.5 cm and h, very superficial, resurface r-A confirmed R43 had no areas at that time.	F 68	36				
	9:28 a.m. and state artificial legs on an	e interviewed on 11/07/19, at ed he did not want to take d off for wound assessment on						

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	` '	E SURVEY PLETED
		245304	B. WING			C 12/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	1 11/	12/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)) BE	(X5) COMPLETION DATE
F 686	stated to RN-A "you ready to leave for d answered, "I know in the director of nursing 11/8/19, at 1:00 p.m practitioner who was rounded weekly with wound assessment expected a dressing and if it wasn't there staff as soon as powas always the first wound assessment refuse. The facility Pressur policy undated, indi Monitoring: a. Stainspections (with danotified to inspect the identified. c. Nurses at least weekly to identified to inspect the identified. C. Nurses at least weekly to identified proceed or Weekly Skin Interview whether this is a near resident) and comp 6. Proceed to car individualized for the risk factors Docur refused the treatment the resident's responsible of refusing the accepting and avail	to be done before. R43 a always" wait until "I" was ialysis with my legs on. RN-A	F6	86		
F 688	Increase/Prevent D	ecrease in ROM/Mobility	F 6	88		12/29/19

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		245304	B. WING _			C 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 688 SS=D	CFR(s): 483.25(c)(§483.25(c) Mobility §483.25(c)(1) The resident who enters range of motion do range of motion un condition demonstr of motion is unavoi §483.25(c)(2) A res motion receives ap services to increas prevent further dec §483.25(c)(3) A res receives appropriat assistance to main the maximum prac reduction in mobilit This REQUIREME by: Based on observa review, the facility f motion exercises for reviewed for limited Findings include: R4 was observed of	facility must ensure that a set the facility without limited es not experience reduction in less the resident's clinical rates that a reduction in range dable; and sident with limited range of propriate treatment and erange of motion and/or to rease in range of motion. Sident with limited mobility the services, equipment, and tain or improve mobility with ticable independence unless a y is demonstrably unavoidable. NT is not met as evidenced tion, interview and document ailed to provide range of or 1 of 2 residents (R4)	F 68	,	areas with sing staff has gency to program and and or palm Maintenance ed to ensure	
	R4's Quarterly MDS R4's cognition was dependent on staff personal hygiene a Quarterly MDS indi	S dated 10/23/19, indicated impaired, was totally assistance for dressing and nd did not reject cares. R4's cated R4 had functional vith both upper and lower		plan is up to date. This has the affect all facility residents. 3.All licensed staff will be insected by the companient of the companient	he potential to serviced by e of motion, nge of motion	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245304	B. WING _			12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 688	R4's Care Area As: 1/11/19, indicated I shoulder arthritis an not indicate location not indicate ROM experformed. R4's Significant Ch (MDS) dated 7/26/2 was impaired and I hemiplegia or hemiplegia	contractures were not carterly assessment. Sessment (CAA) dated R4 had limited ROM, bilateral and contracture. R4's CAA did an of the contracture and did exercises were to be ange Minimum Data Set 19, indicated R4's cognition R4 had diagnoses of Arthritis, iparesis and was hospice care. ange (SC) MDS indicated R4 staff assistance with all ring (ADLs) and did not reject adicated R4 had functional of motion (ROM) with both attremities. Finger contractures on the assessment. 26/19, indicated hospice care R4's CAA indicated R4 had obtion and needed staff to left side hemiplegia, s, weakness and contracture. Indicate location of the Id not indicate ROM exercises	F 68	4. The director of nursing or be responsible for complian be completed on residents of Maintenance Plans to preverence of deficient proceeds, weekly x 1 month armonthly x 1. Results will be our Quality committee for furecommendation.	nce. Audits will with Functional ent ractice daily x 4 and then reviewed by		

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		245304	B. WING		1	C 1/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009		1712/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 688		Therapy (OT) Treatment	F 6	88			
	referred to OT due functional activities joint stability, postu R4's OT note dated hand was in a fist a possible palm prote	ted 4/8/19, indicated R4 was to decline in ability to perform without physical assistance, ral alignment, pain and ROM. d 4/9/19, indicated R4's left and would be placed with ector or splint at night/day. The licate ROM exercises for the erformed.					
	on bed with left fing could not straighter concerned about it the left fingers to go	on 11/7/19, at 1:25 p.m. laying gers curled in. R4 stated she n our her fingers and was . R4 stated she did not want et any worse. R4 tried to open ut could not stretch out her open.					
		nurse (LPN)-D stated on n. she had not assessed R4's ractures.					
	1:40 p.m. NAs did for R4's left hand.	NA)-J stated on 11/7/19, at not perform ROM or exercises NA-J pulled out her NA care ed ROM/exercises was not re sheet for R4.					
	manager, stated or a history of stroke a guarded her left an use her left hand. F restorative therapy done with R4 for co being done by staff	RN)-A, who was also nurse in 11/7/19, at 1:42 p.m. R4 had and frozen left shoulder and im because of pain and did not RN-A stated R4 did not receive in RN-A stated ROM could be comfort but was presently not for RN-A called on the telephone ector (TD) on speaker and					

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		245304	B. WING				C 12/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 300 NORTH DOW STREET CANNON FALLS, MN 550			12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD FO THE APPROPE	BE	(X5) COMPLETION DATE
F 688	asked if R4 had be therapy had worke passive ROM for the management. To sidentified hand/fing was able to open be could evaluate and though. RN-A state R4 to be evaluated left fingers contract. R4 was observed on her Broda chair couple of staff had her left hand finger what had been dechelp with the finger she was not interesonly wanted ROM. Nursing assistant (9:43 a.m. that R4 I stated R4 could opthe left hand, but not her fingers on her could open up her stated she had not fingers up all the we evaluate for contract. HN stated on 11/12 identified contracts stated R4 could on fingers and was got	den seen by therapy. TD stated d with R4 in the spring for the upper part of body for pain stated therapy had not the contractures for R4 and R4 toth hands. TD stated therapy provide three visits she and she would e-mail hospice for by therapy for ROM for her tures. In 11/8/19, at 9:52 a.m. sitting in her room. R4 stated a come and talked to her about as. R4 stated she did not know as not getting worse. R4 stated sted in having a hand splint exercises. NA)-J stated on 11/12/19, at the sher wash her hands. NA-Jen up some of her fingers on ot all the way open. I) stated on 11/8/19, at 11:32 to see R4. HN stated R4 kept left hand curled and stated R4 fingers with some pain. HN noticed R4 could not open her ray and would assess and	F 6	88			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _			12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	,	
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F 688	Continued From pa	age 58	F 68	В		
	had discussed with Occupational Thera hand contractures increase ROM and written.	dated 11/8/19, indicated HN RN-A about ordering an apy evaluation for R4's left to see what could be done to stiffness and order was				
		(DON) stated on 11/8/19, at not aware of R4's left fingers				
		12/19, at 11:48 a.m. R4 should ed for contractures before				
	undated, indicated receive Rehabilitati developed and coo care plan. The policassisted with exercitherapists and wou range of motion ex	azards/Supervision/Devices	F 68	9		12/29/19
	supervision and as accidents. This REQUIREME	resident receives adequate sistance devices to prevent				
	by: Based on observa	tion, interview and document		Base Board Heaters		

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			A. BUILD	ING .			,
		245304	B. WING) 2/2019
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0 . 0
				3	00 NORTH DOW STREET		
THE GAR	RDENS AT CANNON	FALLS			SANNON FALLS, MN 55009		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	١	(X5)
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F 689	Continued From pa	age 59	F 6	89			
	review, the facility	failed to ensure heat registers			R29□s bed was moved away from	base	
		r safe temperatures in resident			board heater immediately on 11/01		
	rooms for 1 of 33	residents (R29) with baseboard			Room audits were done on all roon	ıs on	
	heaters. In addition	n, the facility failed to			the same day to ensure beds were	not	
		assess causative factors of falls			next to the base board heater.		
		mplement appropriate			Temperatures of base board heate		
		of 3 residents (R7) reviewed			checked by the director of mainten		
		to identify and comprehensively			as well. This incident was reported		
		d use of a mechanical lift			Nursing Home Incident Reporting s	ite on	
		e in mobility and develop			11/01/2019.		
		of 1 resident (R30) reviewed			This has the potential to affect all fa	acility	
		nally, the facility failed to			residents.	nanaa	
		n to reduce resident to resident of 5 residents (R15, R33, R55,			Nursing, housekeeping and mainte staff were educated to not to place		
		nemory unit. Furthermore, the			and/or personal items next to heate		
		sess, develop and/or implement			resident rooms.	;15 III	
		omote safe smoking and			Resident rooms.	د	
		for 2 of 2 residents (R43, R25)			checked monthly or when resident		
	reviewed for smok				family has concerns about room	OI	
	TOTION OU TOT OFFICE	g nazarae.			temperature. The maintenance dire	ector or	
	Findings include:				designee audits on room placemer		
	J				temperature of the baseboard heat		
	R29's Significant C	Change Minimum Data Set			monthly x 3. The nursing staff has		
		nt dated 9/9/19, identified			continue to complete weekly check		
		npairment and hallucinations.			weeks then monthly x 1 to ensure s		
	R29's Significant C	Change MDS indicated R29			Results will be reviewed by our Qua	ality	
	required extensive	assistance of two staff for bed			committee for further recommenda	tion.	
	mobility, transfers,	and toileting. In addition, R29's			Falls/INJURY		
		entified to include dementia,			R7 was evaluated by occupational	therapy	
	type 2 diabetes, de	epression and anxiety.			(OT) for wheelchair positioning on		
					9/09/2019 for fine motor coordination		
		e plan identified he had a			heel strike during wheelchair mobil		
		ated to aggressive behavior,			the goal to maintain upright position		
		ociated with dementia,			when in wheelchair. R7 continues t	o work	
		continence. R29 required			with OT and physical therapy (PT).		
		ce of up to two staff to turn and			In addition, a new fall and pain	£.	
		extensive assistance of 1 staff			assessment should be completed a		
		it to stand lift. R29 had			every fall, they will be done by 12/1		
	weakness and limi	ited physical mobility, and			IDT will meet and review R7□s car	e plan	

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TUE 0 4 F	DENG AT GANNON			300 NORTH DOW STREET			
THE GAR	RDENS AT CANNON	FALLS		CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	Continued From pa	ge 60	F 68	9			
	his wheelchair. R2 communication rela associated with der	ated to cognitive loss mentia.		and update as needed by 12/1 All residents in the facility will by the IDT by 12/29/2019 to idepositioning and transferring conthere are any concerns an OT will be done. Any adjustments	ne reviewed entify any ncerns. If evaluation		
	indicated R29 had	lated 11/1/19, at 4:30 p.m, sustained a burn to his left leg. indicated R29's bed was in		will be done. Any adjustments noted in the residents□ EMR a care plan updated as needed.	and their		
	contact with the ele the resident sustair incident report, the	next to the wall and was in actric baseboard heater when ned the burn. According to the maintenance director (M) had		therapy department (PT), OT a therapy (ST) screen all resider their routine IDT reviewal that quarterly.	nts prior to is done		
	cycle. Further the n	naintenance director had e of his inspection, the heater och.		Future residents will be assess upon admission for proper who positioning Audits will be done weekly x 4	eelchair and		
	indicated R29 was	e dated 11/1/19, at 6:36 p.m., discovered by staff with his left t register in his room. The		monthly x 2 to ensure compliant on all falls to ensure fall and parassessment will begin immedia	nce. Audits ain		
	progress note indic centimeters (cm) be outer aspect of the staff had applied a	ated R29's leg had an 8 y 2.5 cm pink, area on the left lower leg and indicated cold compress to the area. In		R30 is transferred with a full be The sling is based on body we accommodate bilateral lower e amputations.	ight and to extremity		
	alert with no signs of subsequently conta	noted by staff to have been of pain. R29's physician was acted and staff received an (burn cream). R29's bed was		Existing residents requiring ful transfers will be assessed for lessafe transfers by 12/16/2019. care plan and care sheets will	parriers to For all, the		
	immediately moved heater. The Admini	I away from the wall with the strator, the director of nursing determined the heater had		This has the potential to affect residents. Nursing staff will be in-serviced	all facility		
	been on long enougheating cycle. Followere checked to er	gh to expose R29's skin at the wing the incident, all rooms usure beds were not placed		full body lift sling sizing and ba safe transfers when a mechan used by 12/29/2019.	rriers to ical lift is		
	was provided to ke In addition, the mai	I heaters, and staff education ep R29 away from the heater. ntenance director was		Audits for full body lift appropri begin 12/17/2019 weekly x 4 w monthly x 2 to ensure complian	reeks then nce.		
		see periodic temperature all heaters for the next 24		Failed to provide supervision to resident to resident altercation			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		E SURVEY PLETED
		245304	B. WING			C 12/2019
NAME OF F	PROVIDER OR SUPPLIER	₹	1	STREET ADDRESS, CITY, STATE, ZIP		12/2010
				300 NORTH DOW STREET		
THE GAR	RDENS AT CANNON	FALLS		CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
	Continued From phours. R29's physician pridentified R29 sus left lower leg. Staf cream twice daily and covered. Observation on 11 R29's electric hear exterior window all During observation 2:29 p.m. with M-A be an electric base outer surface. At trinternal temperature measured by M-A to be 105 degrees metal cover. The degrees F, and the 123 degrees F. M-skin could be at risclose contact with had determined R irradiation from the exiting the vent. Mincident, he had circums assured by M-A to be 105 degrees for the degree for th	LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE DEFICIENCY)	R56, R57) ged from the 33 was sides on the R15 was sh unit this eassessed for tient stay is has been r of nursing and to residents on will continue to resident avior concerns riewed and nd appropriate e residents sion to the ed by the IDT identify target s. on dementia 2019. This ction, ig the next level w people with	DATE
	stated he thought heater surface had	those types of heaters. M-A in order to cause a burn, the d to reach between 133 and and skin needed to be in contact		ever-changing world. Unde world in which we support the provide quality care that all shine.	nelps us to	
	M-A was unaware regulatory guidand sustained after ex 120 degrees F in 6	an extended period of time. of the direction in the ce that indicated burns could be posure to temperatures over excess of 5 minutes. M-A was anufacturer or serial number for		Progress notes, risk manaç will be reviewed every weel behavior concerns beginnir 4 weeks, weekly x 1 month monthly x 1.	kday for ng12/17/2019 x	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
						(
		245304	B. WING			11/	12/2019
	PROVIDER OR SUPPLIER	FALLS		30	TREET ADDRESS, CITY, STATE, ZIP CODE 100 NORTH DOW STREET 12 ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	any of the heaters to recommendations of the heaters had be years. M-A further a were not checked fin the fall of the year had not been remiritems off, or away of had monitored the following the burn, surface temperature. During interview on assistant (NA)-B state concern related to manager, registere week before R29 where week before R29 where week before R29 where weak before R29 where weak before R29 where weak before R29 where was too low an said he had raised higher than the flood but stated he had not the heater on the whole was too low an said he had raised higher than the flood but stated he had not the heater on the whole was used to position, which unbecontact with the heater on the was used to the temperature of the incident and heaters above 120 remember which resulted R29's bed when heater at the tint the burn was initially blister however, R2 result of the burn. It of the interview, the	for safe heater use, and stated en in use for at least 30 to 40 acknowledged the heaters or safety prior to the initial use ar. In addition M-A verified staff aded to move any beds or rom, heaters. M-A stated he temperatures of the room but had not monitored heater es. 11/5/19, at 2:32 p.m. nursing ated he had reported a not heaters to the nurse d nurse (RN)-A, and DON a ras burned. NA-B stated R29's d close to the heater. NA-B the bed up a couple inches or because the heater was hot, not moved the bed away from rall. NA-B said RN-A had be R29's bed in the lowest eknownst to staff, put R29 in ater. NA-B stated he perature of all the room heaters and found 4 or 5 of room degrees but was unable to	F	589	Failed to assess/develop and/or implement interventions to promote smoking/storage practices for smol R43 and R25 R43 and R25 will have smoking assessment, care plan review and re-educated on the facility smoking completed by 12/29/2019. Current smokers will receive re-edu on the facility smoking policy 11/11. Future residents who smoke will cowith smoking evaluation upon adminand will have the facility smoking pereviewed. This has the potential to affect all residents that are current smokers. Facility staff will receive education of facility smoking policy along with smaterial storage and will be completed all residents and resident smoking interventions will be completed dail weeks, weekly x 1 month then monto ensure compliance. Results will reviewed by our Quality committee further recommendation. The director of nursing and/or designal will be responsible for compliance.	be policy ucation /2019. Intinue ission olicy on the moking eted by ing y x 4 thly x 1 be for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245304	B. WING _		11	C / 12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	712/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 689	90 percent (%) cotissue, and the outbeefy red. During interview wia.m.he said he had R29 was unable to his burn, was awar able to be interview. During interview or denied being award the heater temperation hot. DON confirme been monitored inistated she expected and stated staff we next to the heater and DON stated she was had received educated policy was not review. Review of a 11/2/1 identified staff on deep beds away frow was no evidence to were not on duty as been educated on. During interview or medical director (Moresident had received of the circumstance)	gins, with the inner wound bed vered with greenish/yellow er 10 % of the wound bed was the R29 on 11/7/19, at 10:15. In opain in his lower left leg. recall the events surrounding e of person only, and was not ved further. In 11/8/19, at 2:10 p.m. DON e staff were concerned about stures. DON stated there was not be the staff were temperatures had stially after the burn. DON did all rooms to be monitored are educated not to put beds after R29's burn. However, as unable to verify which staff ation, and verified the revised ewed after R29's incident. In 11/8/19, at 2:10 p.m. DON the staff who are the staff who are the staff who at the time of the incident had	F 68	39			
	measures and poli	onfirmed preventative cies should be in place to					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245304	B. WING_		11	C / 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	around heaters to out of the establish burns and expecte provide training to Review of the facili Temperature Polici items were to be k baseboard heaters did not identify what temperature was, I to be brought to m. R30 was interview stated in February following an accide R30 explained his was heavy and dur his leg was "dropp unavoidable kneer cancer in his leg. If the cast staff had a while providing sup R30 was observed in his bed with two unable to use upper observed to use hi his call light and ar R30's Discharge Sidentified R30 was	a policy to establish a safe-zone keep all beds, sheets, chairs led safety zone to prevent d the management team to all staff about heater safety. ty's 12/1/17, Room y identified resident beds and lept a safe distance from the let to prevent hazards. The policy at a safe distance or safe but indicated all concerns were	F 6	39		
	was to be worn. The facility investig identified R30 had	pative file dated 3/2/19, a knee immobilizer on his left bidental fracture, however R30				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
		245304	B. WING		1	C 1/12/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009		1712/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	went to the hospital pain while at the hold a "fracture by was confirmed as a previous fracture" I "his leg was hit on (NA) reminded to home support during transwas one of the NA during that time. R30's incident reported "the staff hoyer one staff was it up straight the colleg, resident stated guiding his legs drown R30's Emergency 3/2/19, indicated R	all related to complaints of chest ospital R30 was found to have knee." The file indicated this a "new extension of the R30 indicated on 3/5/19, that the lift" and nursing assistants handle R30's left leg to ensure asfers. The file identified NA-K who had worked with R30 out dated 3/2/19, indicated R30 was transferring him in the sin the back helping resident other staff guiding resident other staff guiding resident's at that the nursing assistant opped his leg, causing pain."	F 6	89		
	tibia closed with no well. R30's annual MDS had intact cognition included quadriple MDS indicated R30 his transfers. R30's care plan rewas totally depend directed staff to promechanical lift for the R30's Diagnosis re	as diagnosed with a fractured ofted surrounding sclerosis as dated 9/16/19, identified R30 in and diagnoses which gia and anemia. The annual 0 required total dependence for wised 9/17/19, identified R10 ent on staff for all cares and ovide assist of two staff with full transfers.				
		kin of left lower limb, right and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTI	RUCTION	(COMI	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	FALLS		300 NORT	DDRESS, CITY, STATE, ZIP CODE TH DOW STREET I FALLS, MN 55009	=	117	12/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHO OSS-REFERENCED TO THE APP DEFICIENCY)	DULD E		(X5) COMPLETION DATE
F 689	R30's medical recoreassessment of trafollowing his left low 2/15/19. DON was interview and stated it was he communicate when difficult and the resiproper equipment at 4:17 p.m. and stanother NA transfer NA-K recalled he wanother NA was ho had his leg in a large the transfer having brace and the supp NA-K stated during hit his leg on the lift.	ge 66 rd lacked evidence of ansfers with the mechanical lift wer extremity fracture on ed on 11/8/19, at 1:20 p.m. er expectation for staff to a resident transfers were ident would be reassessed for and lift use. red via telephone on 11/12/19, ated he had assisted with r R30 with the mechanical lift. as controlling the lift while Iding R30's leg due to R30 is leg ort needed for R30's leg. the transfer R30 "accidentally" as R30 was unable to keep	F 6					
	on when up in the li indicating his leg hu lift. NA-K was unab notified regarding F regarding R30's diff. The facility Safe Lif Residents Policy ur safety, dignity, com would be incorporar regarding the safe I The policy indicated resident needs for the completed on an ordocument resident.	omfortably with the leg brace ft. NA-K remembered R30 art from hitting his knee of the le to recall if the nurse was 830's leg hitting the lift and/or ficult transfers with the lift. Iting and Movement of adated, indicated resident fort and medical condition ted into goals and decisions ifting and moving of residents. It assessments of individual transfer assistance was agoing bases and staff would transferring and lifting needs e policy indicated the						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION ING	COM	TE SURVEY MPLETED
		245304	B. WING			C / 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COI 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F 689	assistance, resident resident size, weight status, if the resident and resident goals. movement of resident safety program white identifying problem. R7's Fall Risk Assessindicated R7 was a R7's Quarterly MDS R7's cognition was than two times since completed on 8/1/1 indicated R7 had digeneralized muscle MDS indicated R7 had digeneralized muscle MDS indicated R7 in assistance with transitiving and did not resident in his wheelchair (wupright in his w/c. R7 was observed on whe had to go to the later Registered nuwith an EZ stand (in R7 was observed on w/c in his room whe had to go to the later Registered nuwith an EZ stand (in R7 was observed on w/c in his room we sitting upright. R7 sight, no hurt, it justices.	include resident preference for t degree of dependency, at bearing ability, cognitive and was cooperative with staff. Furthermore, safe lifting and ents was part of an overall ch involved employees in areas. Sesment dated 10/27/19, High fall risk. Sedated 10/28/19, indicated intact and had fallen more the last assessment 9. R7's Quarterly MDS agnoses which included weakness and anxiety. R7's needed extensive staff asfers and all activities of daily	F 6	89		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	E SURVEY PLETED
		245304	B. WING			C 11/12/2019	
	PROVIDER OR SUPPLIER			300	EET ADDRESS, CITY, STATE, ZIP CODE NORTH DOW STREET NNON FALLS, MN 55009		12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	NA-J stated on 11/fall risk and had fa thought R7 slides on R7 always sits like R7 sleeps in his was hanging up or of reach in a plastinever seen R7 use R7 was observed in his w/c in his root back. R7 stated he out of the w/c onto stated he had not giust forgets to use thought he was slehe fell and he had R7 stated the seat the back up his w/c would be more conneeded a larger w/forward. Review of R7's fall -R7 was found on 6/11/19, at 11:49 p R7 stated he was his w/c to his kneed cause was indicated R7 was found on 6/18/19, at 9:45 a. Report indicated R7 was a sitting up straight. was indicated on the R7 was transferred.	Incident reports revealed: The floor in his room on incident reports r	F6	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245304	B. WING		11/12	/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 689	progress note. No-R7 was found on at 9:48 a.m. Incide he was reaching w No intervention for the reportR7 was found on at 6:30 p.m. Incide he had leaned too his w/c. No intervendicated on the re-R7 was found on at 10:50 p.m. with Incident Report increpositioned himse intervention for rooreportR7 was found on 11/6/19, at 9:25 p.r w/c. Incident Repobeen reaching for I out of his w/c. No i indicated on the re Review of R7's prothrough 11/6/19, reinterventions put in effectiveness of a reoccurring falls. R7's nursing home 10/10/19, indicated able to get up som ask for help."	Fall Incident Report received. The floor in his room on 7/1/19, nt Report indicated R7 stated hen he slipped out of his w/c. root cause was indicated on the floor in his room on 9/2/19, nt Report indicated R7 stated far forward and slipped out of ntion for root cause was port. The floor in his room on 9/7/19, his back to the front of his w/c. Licated R7 stated he had elf and slid to the floor. No the cause was indicated on the the floor in his room on m. between his night stand and ret indicated R7 stated he had his remote and slipped and fell intervention for root cause was	F 689				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		C 11/12/2019		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	care plan did not in of a reacher. DON stated on 11/interdisciplinary tea intervention for each R7's falls were from should use a reach there was a reached she thought R7 fall asleep in his w/c and explained R7 was R7 had seen a neurand lower symptom to be scheduled for RN-A, nurse mana p.m. she was unawareports and to talk DON stated on 11/daily Monday through the state of the falls. DON stated the nuresponsible for care the fall intervention follow residents' calls indicated staff wou attempt to define pof the fall and ident to prevent subsequents.	8/19, at 10:09 a.m. the am (IDT) had not made an ch one of R7's falls as most of m "reaching". DON stated R7 her but stated she did not think er in R7's room. DON stated is were actually from him falling and not from him reaching, and always "sleepy". DON stated irologist for right side upper and of numbness and was going a radditional testing. ger stated on 11/8/19, at 1:00 railable to go over R7's fall with DON about R7's falls. 8/19, at 1:02 p.m. the IDT met igh Friday and discussed in the stated R7 had just fallen was trying to come up with an antion for his falling for the stated R7 for fitting of his w/c. Its managers were e planning and implementing its. DON stated staff should	F 68	9			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245304	B. WING _		11	/12/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	Continued From pa	age 71	F 68	9		
	relevant intervention the nature of the the stops or until a reasont continuation. R15's face sheet in	ted, staff were to try various ons, based on assessment of the fall until falling reduces or son is identified for its				
	dementia with behadisorder, affective depressive disorder	nosis of Alzheimer's disease, avioral disturbance, anxiety mood disorder, major r, pseudobulbar affect luntary laughing or crying) and				
	Brief Interview for I had severe cognitive 1-4 days during assupervision with be eating. R15 required dressing, toileting a	OS dated 8/22/19, indicated Mental Status identified R15 we impairment. R15 wandered sessment period, needed and mobility, ambulation and ed extensive assistance with and personal hygiene. R15 tic, antidepressant and diuretic				
	indicated R15 requ wanting to leave th R15 had severe co	ssessment dated 12/7/18, ired a secured unit due to her e facility and her memory loss. In it is impairment and was what others were saying and id.				
	R15 had the potent related to dementia R15 was bothered independent with a Interventions include agitated to intervent	nted on 11/6/19, indicated tial to be physically aggressive a, and poor impulse control. by loud noises. R15 was imbulation and transfers. ded: When R15 became before agitation escalates, and source: Monitor and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245304	B. WING		11/12/2019		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		12/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 689	or others; Staff to be unit and keep R15 invade her personaneeded; Redirect wat risk for doing so distress; Monitor procurrences. Review of Daily Sta 2019, revealed that staffed during day and the night shift. Review of R15 res Vulnerable Adult (Valnerable Adult	is of R15 posing danger to self be aware of R15 activity on the from residents that tend to all space; Cue and supervise as when R15 seems confused or mething that might cause acing, wandering or crying affing Sheets since July of the 300 memory unit was and evening shift with two staff one staff. Ident to resident altercations (A) - Incident reports revealed altercations since July 2019, ession with other residents. It was able to place her hands and then reach out to hit R56 staff could intervene. Report that awareness of other behaviors was key to keeping secure.	F 68	9			
	(LPN) heard screa got within eye sigh punching each oth indicated that the s the time of the alte -On 10/11/19, R55 near the exit door walk up behind R5 seen to get up from pushing R15 befor -On 10/22/19, R55 and R15 walked up	n licensed practical nurse ming and swearing. When LPN t she found R15 and R55 er in the face. The report also second staff was off the unit at reation. was sitting in his wheelchair when R15 was observed to 5 and rub his head. R55 was in his wheelchair and starting e staff could intervene. was sitting in his wheelchair or and leaned in and said then slapped him in the face.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245304		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING		11/12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 689	with her open hand On 11/4/19, at 1:17 sitting at the table present. At 1:20 p. (LPN)-F entered the got up and walked room. The common three minutes whee On 11/4/19, at 5:27 sitting at a table yet table walked over the about a fist in yexactly what she some there were no start where these two rekitchen staff entered by a direct care start unsupervised for formal of the staff entered by a direct care start where these two rekitchen staff entered by a direct care start unsupervised for formal of the staff entered by a direct care start where these two rekitchen staff entered by a direct care start where these two rekitchen staff entered by a direct care start where these two rekitchen staff entered by a direct care start where the staff entered to care where the staff entered to common area where assisted the other returned to common residents sitting at	d before staff could intervene. 7 p.m. R15 was observed in common area with no staff im. licensed practical nurse in common area just as R15 down the hall to go enter a in area was unsupervised for ite R15 was sitting. 1 p.m. R33 was observed alling and R15 got up from her ite R33 and stated something to your nose (unable to identify aid) then returned to her table. If present in the common area is identify were. At 5:25 p.m. and the common area followed aff. The common area was	F 68	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245304	B. WING		11/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AR DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	LPN-A left the comresidents including staff arrived to comwas unsupervised. On 11/6/19, at 11:1 walking down the hanother resident roin the common are visually see R15 ar. On 11/7/19, at 7:51 with residents (including the other staff in a returned to the conunsupervised for fiv.) On 11/8/19, at 7:58 to go into a resider including R15 unat area and hallway. For foom to common unsupervised for side of the composition of the co	mon area where there were R15. At 8:30 a.m., kitchen area. The common area for eight minutes. If a.m. R15 was observed allway and both staff were in som. There was an activity staff a but this staff was unable to add her whereabouts. If a.m. LPN-K left common area uding R15) present to assist room. At 7:56 a.m, LPN-K amon area having left the area we minutes. If a.m. both staff are observed at room leaving five residents tended within the common at 8:03 a.m. TMA-B came out area that had been left ax minutes. If a.m. at 5:25 p.m. NA-D ways had aggressive behaviors area that here. NA-D stated medications to give on the area 200 wing so that left NA-D it was very hard to monitor ated that when she needs esident the nurse was the one rifies that the residents were	F6	89		
	indicated monitorin as R15 was very ke	n 11/5/19, at 8:53 a.m. TMA-A g R15 included watching her een on another male resident. cannot monitor all the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	245304		B. WING			C 11/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP OF STATE AND STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	and that was a safe The activity director 11/6/19, at 10:20 a department did not memory unit. AD st called to assist with memory unit while it was not part of the The assistant direct interviewed on 11/6 indicates that R15 Is she lashed out unpkept an eye on R15 be always in eye signatif need to be in a the common area to someone monitoring other residents with R15 continued to haltercations with now as unsure if anyonal tercation happener pattern. During interview on indicated R15 was on one to one superhave those resource residents on that un assistance and dur radio call for assistance and dur radio call fo	are in getting residents up"	F 68	9			

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
		245304			11/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	should have always view of the hall an stated there were to the nurse went to go carried radios so the On 11/7/19, at 8:45 stated staff were eashe was in the common area at alknow what they will residents for aggree behaviors towards. Review of the 9/27 Procedure indicate measures to addressing prevention Program committed to prote policy also indicate and patterns of pot changes to prevention. R43's annual MDS was current tobact cognition. R43's ardiagnoses included disease, periphera diabetes mellitus. If	P.p.m. RN-A indicated there is been one staff within eyes do common area ideally. RN-A imes that did not happen as give pills but that was why staff ney can ask for help. S. a.m. licensed social worker expected to be with R15 when amon area. B. p.m. NA-I stated someone esidents when they were in the I times because "you never I do." Resident to Resident dentified staff were to monitor essive or inappropriate others. 19. Abuse Policy and do staff were to institute essive or inappropriate others. 19. Abuse Policy and do staff were to institute essive or indicated staff were ct residents from abuse. The dot staff will identify occurrences ential abuse and implement the future occurrences. 19. Abuse Policy and dot staff were ct residents from abuse. The dot staff will identify occurrences ential abuse and implement the future occurrences. 19. Abuse Policy and dot staff were ct residents from abuse. The dot staff will identify occurrences ential abuse and implement the future occurrences. 19. Abuse Policy and do staff were ct residents from abuse. The dot staff will identify occurrences ential abuse and implement the future occurrences. 19. Abuse Policy and dot staff were ct residents from abuse. The dot staff were ct residents fr	F 64	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245304			(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED	
		245304	B. WING		C 11/12/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	11/12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLÉTION
F 689	R43 did not curren smoke. The review smoking related in self, burning clothin ashes on self" and smoking apron" an smoking. The revie policy related to smoking materials evidence regarding materials. R43's Care Plan re R43 was currently assist R43 in wear he went to smoke, and hazards, smoof facility policy on smoconcerns, notified was suspected R4 policy, observed clicigarette burns, R4 using a cigarette h his lap. R43 was a keep lighter, smook bedside. R43 Progress Note 8/30/19, through 16 following: -On 8/30/19, the P Nursing (DON) observed (DON) obs	view dated 10/15/19, identified tly smoke, however intended to a indicated R43 had a history of cidents which included burninging, burning furniture, dropping indicated R43 "must wear and utilize cigarette holder when the endicated staff reviewed the noking times and storage of with R43, however lacked a smoker and directed staff to ing smoking apron every time instruct about smoking risks king cessation aids, instruct noking: locations, times, safety charge nurse immediately if it 3 had violated facility smoking othing and skin for signs of 13 could smoke unsupervised, older and smoking apron on ble to light his own cigarette, ing supplies and roller at the (PN) were reviewed from 0/29/19, and revealed the N indicated the Director of served two open areas on inger and middle finger. R43	F 689		
	was identified as a middle finger to ho dated 8/30/19, indi	smoker and used "index and ld cigarette." A subsequent PN cated R43 was noted with burn hat was related to smoking			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245304	B. WING_			C / 12/2019
	ROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		712/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	supervision on the R43 did not wish to smoke off of the property of the protective devices apron, R43 had agreement aprotective devices apron, R43 had agreement R43 steducated to wear the designated smoking privileges devices for smoking. R43 was observed the designated smoking. R43 was observed the designated smoking. R43 was observed the designated smoking privileges devices for smoking as smoking.	unsafe to smoke without property. The PN indicated of stop smoking and agreed to operty; N indicated Social Worker 43 about not being safe to a holder to protect R43's gran apron to protect R43 from N indicated R43 was assessed to smoke with the following cigarette holder and smoking reed to use both of the N indicated R43 was observed de smoking "with out his moking apron per facility ated "I just got back". R43 was he smoking gloves and apron N indicated R43 lost his due to not wearing his safety	F 68	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
245304			B. WING _		11	11/12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	712/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	stated that "the sta any instruction abore stated he did not he unable to locate his indicated it was ok and lighter unlock of time of the interviewhad his cigarette, to top of his bedside to the NA-C was interviewed and stated R43 sm was unaware of an smoke. LPN-D was interviewed and stated R43 newent to smoke. LP supposed to go our cigarette holder. Lese R43 without a remind him he needed to be a single property of the complete was fit. DON confirmed cigarette holder in DON stated R43 have garding use of his regarding use of his regarding use of his needed to contact the state of the complete was fit. DON stated R43 have garding use of his regarding use of his cigarette was fit.	ed on 11/6/19, at 8:50 a.m. and ff does not tell me or give me out going out to smoke." R43 ave cigarette ring or holder and a smoking apron. R43 for him to leave his cigarette on his bedside table. At the w R43 was observed to have obacco and lighter unlocked on table. Wed on 11/6/19, at 8:41 a.m. noked independently and NA-C by supplies R43 needs to Ewed on 11/6/19, at 11:08 a.m. over notified anyone when he N-D indicated R43 was twith a smoking apron and PN-D stated when she would smoking apron, she would ded one. Wed on 11/08/19, at 1:14 p.m. over notificult of ind a right ring that R43 should have had a his room available for use. and been non-complaint s smoking apron and cigarette of staff would spot check to	F 68				
		g Policy-Residents revised					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	e) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		245304	245304 B. WING		C 11/12/2019		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	not comply with rule asked to restrict privileges. Policy in would be complete and "Any smoking and concerns (for monitoring fire retanoted on the care for the resident shamber of the shamber of the shamber of the resident shamber of the shamber	les regarding smoking would t and/ or forfeit their smoking indicated smoking assessment and before resident could smoke prelated privileges, restrictions, example, need for close ardant smoking aprons) shall be plan, and all personnel caring all be alerted to these issues be returned to nurse's station	F 68	9			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _		11/12/2019		
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 689	nursing station to a their rooms because to the ombudsman were property of the R25's care plan dawas a smoker and resident will not sufpractices through the resident about smoking cest Instruct resident about smoking: locations Monitor oral hygien immediately if it is eviolated facility smoking that is not signed to the resident about smoking or signed and skin for signed can smoke unsuper (light own cigarette R25 signed a smoke policy dated 9/20/1 be in a locked box smoking products and the residents we cigarettes or supplice Social Worker (LS) 11/8/19, at 8:42 a.r. current smoking probecause cigarettes personal property combudsman. LSW	from being locked at the allowing residents to keep in se there was a complaint made who indicated the materials e residents. Ited 10/14/19, indicated R25 outlined the following: The ffer injury from unsafe smoking he review date; Instruct oking risks and hazards and sation aids that are available; bout the facility policy on times, safety concerns; lee; Notify charge nurse suspected resident has oking policy; Observe clothing of cigarette burns; The resident ervised; The resident is able to: keep lighter at bedside). It is policy on 9/20/19. The set is the nurses' station, that all will be stored in the locked box were not permitted to keep tes in their possession. W)-A was interviewed on m. and confirmed that the olicy could not be enforced and supplies were considered of the residents per the V-A also stated if the resident	F 68	9			
	forced to wear an a to have a smoking be unsafe, the privi	clothes, they could not be apron. Residents were required assessment and if deemed to ilege was taken away. The					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (7	(X3) DATE SURVEY COMPLETED	
		245304	304 B. WING		C 11/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	1111212010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 689	aware that R25 kep LSW-A stated she indicated the lighter	be safe. LSW-A was not of lighter fluid in his room. did not do room searches, but fluid would be taken away.	F 689		12/29/19	
SS=F	the appropriate conprovide nursing and resident safety and practicable physical well-being of each president assessme and considering the diagnoses of the fall accordance with the at §483.70(e).	nt Staff. live sufficient nursing staff with inpetencies and skills sets to direlated services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by ints and individual plans of care in number, acuity and cility's resident population in a facility assessment required				
	by sufficient number types of personnel nursing care to all resident care plans (i) Except when was this section, licensed (ii) Other nursing pelimited to nurse aid \$483.35(a)(2) Exceparagraph (e) of this designate a licensed nurse on each tour	ived under paragraph (e) of ed nurses; and ersonnel, including but not es. pt when waived under s section, the facility must d nurse to serve as a charge				
		tion, interview and document ailed to ensure sufficient staff		1.It is the facility policy to ensure we sufficient staffing to meet the needs		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245204	B. WING			(
NAME OF I	PROVIDER OR SUPPLIER	245304	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	11/1	2/2019	
	RDENS AT CANNON	FALLS		30	00 NORTH DOW STREET ANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 725	were available to make the control of the control o	deet resident needs for 4 of 5 a, R46, R7) dependent on staff (ADLs) and for 5 of 9 a, R18, R37, R51) whom s during resident council n, the facility failed to provide ce resident to resident 5 residents (R15, R33, R55, emory unit. The lack of taffing had the potential to hats in the facility. On 11/8/19, at 7:40 a.m. with 7:59 a.m. R44 indicated he ad pan waiting for "30 to 45 and assistance to get off of the "been done for a long time." If g assistant (NA)-A was a r R44's call light when entering atted to NA-A he had been I should." R44 was observed atted R44 off of the bed pan. The had been waiting "45 a replied "we are working as	F 7	725	residents in the facility. Residents FR12, R18, R24, R37, R43, R44, R4 R51 care plans were reviewed to ewe are meeting their ADL needs. Tresidents R15 and R33 care plans reviewed that ensure we are meetin needs of those residents to reduce resident to resident altercations. R5 deceased and R56 and R57 have to discharged from the facility. 2. We reviewed all residents care plensure we sufficient staffing to meen needs of all residents. This has the potential to affect all residents in our facility. 3. All nursing staff were in serviced ADL care and supervision of the mecare unit by 12/29/2019 4. The staffing coordinator or design be responsible will be responsible frompliance. Audits will be completed to a month them weekly to a month them themselves and the reviewed our Quality committee for further recommendations.	66 and Insure hen were ng the any 55 is been ans to et the ur on emory nee will for ed daily nen		

a long time for assistance from staff after alerting

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _		11	11/12/2019
	OVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
hoow Nan "idh Nah hbiru U T1 oo tti u taa T1 s	ccur almost daily a reekends. IA-A was interview nd confirmed R44 ninutes on the bed really far behind gue to only having ave had three NA IA-J was interview nd verified there wave had three NA ehind due to having allocated there were pout of bed. The Staffing Direct 1/8/19, at 9:01 a.r. nly two NA's work needed three Namble to find a number of pour of the director of nursing the direc	tated facility staff issues would and was worse on the wed on 11/8/19, at 8:20 a.m. was waiting at least 30 dpan. NA-A stated they were getting residents up for the day two NAs when they should s. wed on 11/8/19, at 8:25 a.m. were only two NA's and should s. NA-J stated they were ng been "down a staff" and re still five resident's left to get or (SD) was interviewed on m. and confirmed there were ing on the 200 unit instead of IAs. SD explained she was rese to work so the facility had ork as the trained medication	F 72	25		
p n re	eripheral vascular nellitus. The annua equired supervisio	r disease and diabetes al MDS further indicated R43 on and/or oversight with ADLs.				

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245304	B. WING_			/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP O 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 725	through 11/7/19, are every Thursday at and the documentate on 9/15/19, the rebathing; -On 9/22/19, the respective of the policable;" -On 10/13/19, the respective of the policable;" -On 10/27/19, the respective of the policable;" -On 10/27/19, the respective of the policable;" -On 10/31/19, the respective of the policable;" -On 11/7/19, after sindicated extensive of the policable;" -On 11/7/19, after sindicated extensive of the policable; and the policable of th	age 85 and directed staff to shower R43 8:00 p.m. male caregiver only ation revealed the following: aport indicated R43 refused aport indicated bathing "Not apor	F 72	25			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245304	B. WING				12/2019
	PROVIDER OR SUPPLIER	FALLS		300	REET ADDRESS, CITY, STATE, ZIP CODE NORTH DOW STREET NNON FALLS, MN 55009		12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	underneath the nail on them, and R43 when had not had a sl when he had reque to assist him. NA-B was interview and verified R43 haweeks. NA-B stated resident's whom recares and/or transienough staff to conexplained in addition two staff there were required two staff a constant behavior imeet the resident's stated the staff had however indicated in NA-C was interview and confirmed R43 while. NA-C explair miss" their scheduli would be moved to day due to not enough as not time to look plans due to having most days there we residents and the significant care needs or basic care was prior stated the staff had have enough staff to needs, however income to the staff had have enough staff to needs, however income to the staff had have enough staff to needs, however income to the staff had have enough staff to needs, however income to the staff had have enough staff to needs, however income to the staff had have enough staff to needs, however income to the staff had have enough staff to needs, however income to the staff had have enough staff to needs.	I, dirty clothing with food stains was malodorous. R43 stated nower in over two weeks and sted no staff would come back and other weeks and sted on 11/5/19, at 2:32 p.m. and not had a shower for three of there were too many quired two people to provide fers which would result in not applete showers. NA-B on to residents whom required the also too many lifts which and resident's whom required the nest care needs. NA-B complained to the DON, nothing changed. In the time the residents the next day and/or the next day and/or the next day and/or the next day staff. NA-C indicated there is at updated resident care in been too busy. NA-C stated the extension of the pool of the residents. NA-C stated the residents. NA-C stated for the residents. NA-C stated for the residents. NA-C stated for the residents. NA-C notified the DON they did not to meet the resident care dicated no changes occurred.	F7	25			
	Licensed practical interviewed on 11/6	nurse (LPN)-C was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		11	C / 12/2019	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 725	on average the stawith two NAs vs. the with two NAs to contend the unit. LPN-C colong time for their indicated "we don' nurse manager and ue to state having DON was interviewed and stated it was head to state it was head to been showered subsequent DON 11/12/19, at 9:14 a increased staffing all caught up show NA-J was interviewed and stated there we toileting and bathin done. NA-J indicated to acuity and 200 unit needed for care timely. The facility policy requested, but not Resident Council On 11/6/19, at 1:2 council group met council function. Tand provided the f-R24 stated "nothing the resident council function."	aff would work on the 200 unit have NAs and indicated to get done as it was not realistic applete all of the basic cares on infirmed residents would wait a call lights to be answered and to always have the DON and aswering lights" they did that gobeen here. Wed on 11/8/19, at 12:07 p.m. her expectation for R43 to be shower schedule which was east she expected a male staff to equest and confirmed R43 had do in the past two weeks. A dinterview was completed on a.m. and stated the facility on the weekend and was now wers. Wed on 11/12/19, at 9:25 a.m. were not enough NAs and and showers would not get the three NAs were not enough care needs. NA-J stated the pur NAs to complete resident regarding toileting was	F 72	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING			C / 12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 725	follow-up with our -R12 stated reside call lights to be an -R18 stated she hassistance and induring meal times "longer" for the castated staffing had couple of months; -R37 stated wait tincreased during times he would not enough staff; -R51 stated there light response and not always able to regarding getting. Resident council reletters were review and revealed the family their call light with -A letter dated 5/7 council lacked eviconcerns; -The minutes date regarding call light times and call ligh without providing the minutes date regarding call ligh times and call ligh without providing the minutes date average 45 minutes minutes indicated turned off without minutes further incompared to the massistance and incompared to the minutes further i	er nobody did anything to concern; ents had to wait a long time for swered; ad to wait a long time for staff dicated if you were in your room you would have to wait even II light to be answered. R18 d gotten worse over the past me for staff assistance had he past few months and at the get showers due to not were long wait times for call d indicated due to this staff were accommodate his choice up at 4:30 a.m. meeting minutes and response ved 4/24/19, through 10/30/19,	F 7	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDII		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245304	B. WING		11	C / 12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 725	baths were not being. The minutes dated were frustrated reg feeling as nothing volume and five still no follow up on the minutes dated expressed regarding overnight shift and regarding long call. The ombudsman (11/6/19, at 1:37 p.r. repeated staffing is complained there were their care needs arout to DON a week concerns, however. The Facility Assess indicated the assess what resources were sidents competed operations and emscheduled to ensur meet the needs of and further indicated based on census a appropriate support assessment indicated to have had a 1:11 1:14 ratio during on the assessment further was nurses. Furthermore assistance with activity and the staff of the covernight there was nurses. Furthermore assistance with activity and the staff of the covernight there was nurses. Furthermore assistance with activity and the covernight there was nurses. Furthermore assistance with activity and the covernight there was nurses. Furthermore assistance with activity and the covernight there was nurses.	ng completed; d 7/31/19, indicated residents arding no resolution and was being done regarding the d 10/10/19, indicated 20 staff were in attendance and long call light wait times; d 10/30/19, indicated concerns ng not enough staff during the still waiting for a response	F7	25			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245304	B. WING			1	C 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS 300 NORTH DOV CANNON FALL		1 111	12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	/IDER'S PLAN OF CORRECTIC CORRECTIVE ACTION SHOULI EFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	resident range 1-20 residents 1-20 and 1-20 and behaviora 1-20. The staffing director 11/8/19, at 9:01 a.m. staff one NA on the 200 unit and one Nourse per unit on dovernight shift ther one nurse for the 1200 and 300 unit. If the following staffing were reviewed 10/m. revealed the following staffing were reviewed 10/m. a.m. until 6:00 a.m. the 200 and 300 unitse, SD verified 1:33 to 40; -On 10/18/19, the second staff the NA ratility. The posted SD verified census indicated the nurse overnight shift them facility. The posted SD verified census indicated the nurse overnight shift them NAs in the facility. reviewed and SD verified	ssistance for an independent 5, one to two staff range of dependent resident range at health needs resident range of the late and stated the facility would be 100 unit, three NAs on the late A on the 300 unit plus one ays/ evenings. SD stated on the would be one NA per unit, 00 unit and one nurse for the During the interview SD verified and schedules and posted hours 1/19, through 11/12/19, and ing: chedule indicated there were 0 unit, SD verified the NA ratio 15 to 16; schedule indicated from 4:00 the 200 unit NA covered both on the with assistance from the the NA ratio would have been 1:15 to 16; schedule indicated the evening are NA on the 200 unit, SD or would have been 1:15 to 16; schedule indicated during the ewas only one nurse for the staff hours were reviewed and was 57 on 10/20/19, which	F 7	25			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		11	C / 12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	1	
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F 725	day shift there were with a current cens 1:15 to 16. The administrator a 11/8/19, at 1:33 p.r the facility assessmindicated their NA administrator verification action around 1:12.3 administrator explain on acuity and indice was 0.9 which was was below their go. The administrator is staff based on acuity and indice would need have be DON verified the faresident's whom retotal dependent on the full body lift. The additional residents assist due to behave was used, howeven umber of resident. During interview with 11/12/19, at 4:32 per QAPI meetings and stated there is a longet staff response discussion had been wait time and staffice.	and DON were interviewed on m. The administrator verified nent was not accurate having ratio was a 1:11. The ed on most days and when the staffing ratio would have 75 or greater. The ained they also staffed based ated their current case mix used to determine acuity and al of greater than 1.0 for acuity. Indicated in order to increase ity their case mix number seen greater than 1.0. The acility currently had 12 esided in the facility who were staff for transfers with use of the DON indicated there were so whom required two person viors and when the stand lift or did not verify the actual its. Atth medical director (MD) on a.m. MD stated he attended the dwas aware some residents ing wait time with call lights to for assistance. MD stated en made regarding call lighting. MD stated, "It was	F 72	5			
	could be improved of any call light wai	ot quite meeting the ratio and "MD stated he was not aware it time audits being completed.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _			/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	112/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 725	Continued From pa	age 92 policy request, but not provided.	F 72	5			
		on 11/4/19, at 6:06 p.m. sitting v/c) in his room with his call s door.					
	R46's cognition wa paraplegia (paralys Annual MDS indica Dependence two s and Extensive two toileting, grooming under Section E- Ir was marked (-) for	dated 10/4/19, indicated s intact with a diagnosis of sis of the lower body). R46's ated R46 needed Total taff assistance with transfers staff assistance with dressing, bathing. R46's MDS indicated aterview for Daily Preferences the interview question "How e your own bedtime?"					
	room two times wit -At 6:17 p.m. direct hallway and told re answer R46's call I needed. RN-A (who	S p.m. a staff walked by R46's hout entering R46's room. tor of nursing (DON) stood in gistered nurse (RN)-A to ight and to see what R46 o was also nurse manager) n and exited and left call light					
	-At 6:19 p.m. R46 phis doorway to the -At 6:23 p.m. DON assistant (NA), "WI DON it was R46 was call light was on an as she had opened over herself and althe toilet. DON told	bropelled himself in his w/c out hall with his call light on. said to unidentified nursing hose call light is on?" NA told aiting to go to bed but R10's ad she wanted staff assistance I and spilled a coca cola all so wanted assistance to go to I NA to go and hook up R46 to went and told R10 she would for was assisted.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 20.22			С	
		245304	B. WING		1	1/12/2019	
NAME OF F	PROVIDER OR SUPPLIEF	3	1	STREET ADDRESS, CITY, STATE, ZIP CC			
TUE 041		541.0		300 NORTH DOW STREET			
THE GAR	RDENS AT CANNON	FALLS		CANNON FALLS, MN 55009			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)	
PRÉFIX TAG	\	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE	
F 725	Continued From p	age 93	F 7	25			
	-At 6:25 p.m. an u	nidentified staff walked past					
		ng a resident in a w/c without					
		needed. At 6:25 p.m. there					
	were four call light	s activated on in the 200					
		A was seated in her office, and					
)-B and licensed practical nurse					
		ing to each other at nurse					
		NA-G, "I will meet you in R46's					
	room."	unidentified NAs entered R4's					
	room with the tran						
	-At 6:27 p.m. DON entered R23's room and told						
		ed to wait and staff would help					
		there are people [residents]					
	ahead of you."						
	-At 6:28 p.m. DON	l entered R46's room and					
		as ready for bed. R46 stated the					
		s room with the lift. R46 he was					
		o get into bed and my program					
	Chicago PD is cor						
	off, DON in R46's	s call light over his door went					
		l exited R46's room and stated					
		see how much longer it would					
	take to get him as						
	-At 6:30 p.m. R29	was observed sitting in his w/c					
		elling, "Help! Help!"					
		l entered unidentified room					
		I call light on above door and					
		all light still activated.					
		observed sitting in his w/c in					
		or assistance to bed with call					
	light on.	all limbte potitions of the ball 000					
		all lights activated in hall 200					
		observed still waiting in his					
	room to go to bed						
	over their room do	and R54's call lights came on					
		wheeled himself out of his					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		245304	B. WING		1	C / 12/2019	
	PROVIDER OR SUPPLIER	FALLS	STREET ADDRESS, CITY, STATE, ZIP (300 NORTH DOW STREET CANNON FALLS, MN 55009				
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F 725	told R46 she could while he was waitin -At 6:44 p.m. R46 vin his room with RN transfer liftAt 6:47 p.m. NA w RN-A to transfer Reminutes for staff as -At 7:18 p.m. R46 s go to bed at 6:00 p he "waits that long the usual." NA-B stated on 11/many lifts and too renough staff and the had to wait over an bed. NA-B stated rat the last step of the lift and the resident last. NA-B stated the wash residents up. generally the norm LPN-C stated on 1 could not be comple NAs. LPN-C stated and generally coup only two NAs instead and generally coup only two NAs instead he cracked down on lights before assist R46 gets left to the leave him and since price. LPN-C stated manager aren't ansert R46's care plan days was sufficiently stated and generally coup only two NAs instead and generally coup only two NAs i	ooking down hallway. RN-A get R46 hooked up to the lift ing. was observed sitting in his w/c N-A present hooked up to the ralked into R46's room to assist 46 to bed. (R46 waited 41 sistance). Stated to surveyor he wants to .m. every evening. R46 stated all the time to go to bed, it's room to get help to get into residents who needed less care the process to bed went to bed onts who required more steps here was not enough staff to NA-B stated that was here at the facility. 1/6/19, at 2:21 p.m. showers reted when only having two I last Sunday only had two NAs alle times a pay period ran with and of three NAs. LPN-C stated on the NAs for turning off call ing resident.	F 72				
		or hedtime at 6:00 n m					

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED				
		245304	B. WING _		1	C 1/12/2019	
	ME OF PROVIDER OR SUPPLIER E GARDENS AT CANNON FALLS 4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 725	Continued From pa	age 95	F 72	25			
	p.m. R46 can go to knew that. RN-A st time was not identi	bed at 6:00 p.m. and all staff ated R46's preference for bed fied on R46's NA care sheet					
	go to bed at 6:00 p DON stated staff sl	.m. as it was his preference. hould accommodate this and					
	would be allowed to consistent with the including sleeping. facilitate resident c information about r upon initial assessi	7/25/16, indicated residents of choose schedules that are ir interest for daily routine. The policy indicated to hoices staff would gather esidents' personal preferences ment and periodically tument these preferences in					
	indicated staff wou	ted, Answering the Call Light ld answer residents' call lights e and respond to residents' s.					
	in his w/c near fron wait for help in the wrapped and get w transferred him to I stated he asked the at this time but the could not as she wneeded to wrap his	on 11/4/19, at 6:55 p.m. sitting t desk. R7 stated he had to mornings to get his legs tashed up. R7 stated night staffinis w/c at about 5 a.m R7 enight nurse to wrap his legs night nurse had told him she as too busy and the day nurse legs. R7 stated he wanted his night op because his					

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		245304	B. WING			C / 12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP O 300 NORTH DOW STREET CANNON FALLS, MN 55009			
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F 725	physician had told wound for his legs and the wound wound R7's Annual MDS of cognition was intacted in the series of the series	thim it was better for his leg to be wrapped when getting up all heal faster. Idated 8/1/19, indicated R7's and included a diagnosis of ty. R7's Annual MDS indicated we staff assistance with all activities of daily living. R7's did not reject cares. Id 6/27/19, indicated R7 was to devices applied to both lower morning and taken off at plan indicated R7 had a solower right leg. In dated 11/7/19, indicated R7 bression devices to bilateral applied daily related to selling of fluid). In at 10:23 a.m. his legs had morning at 8 a.m. because of the completed every Wednesday. The date of the legs wrapped when he in an indicated R7 stated we wrapped his legs and stated wrapped when he got up, and to the toilet and had been all the legs (RN)-A walked into led R7 what he wanted. R7 told	F 7	25			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245304	B. WING _		l	/12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 725	R7 was observed wrapped. R7 state (LPN)-D had wrap 10:15 a.m. R7 state wrapped when the night staff would near told him the mounds will go awar RN-A who was als 11/7/19, at 1:37 put on at 5 a.m. eachange it on the truso night shift would shift. RN-A stated time change. R7 was observed in his w/c with his land asked the nigh nurse to do it earlies stated, "it is not go to show surveyor a lower left unwrappup in w/c since 4:3 had not applied leg physician had told as soon as he gets Licensed practical 11/8/19, at 10:03 a supposed to wrap day nurse. LPN-E reported to him thi wrapped R7's legs the time change for a.m. to 5 a.m. LF wrapped R7 legs to the state of	on 11/7/19, at 1:33 p.m. legs d licensed practical nurse ped his legs this morning at ted he had wanted his legs in night staff got him up, but the ot, and stated the physician were he wears the wraps his ay. o nurse manager stated on im. R7 could have his leg wraps ach day and stated she would eatment administration record do it at 5 a.m. instead of day she would talk to R7 about the interest of the interest	F 72	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245304	B. WING				C 12/2019
	PROVIDER OR SUPPLIER	FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009				12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 725	p.m. she was not a not wrapped R7's lenight nurse should the time "yesterday at 5 a.m R7 was observed on his w/c in the hal wrapped. R7 stated won't do it now." LPN-E stated on 1 not wrapped R7's lewrapping R7's legs dressing change on NA-J stated on 11/went to a medical a 8:30 a.m. and state today. NA-J stated wrapped when he lat 8:30 a.m. R7 was observed on his w/c in his root stated he had gotte appointment at noot stated.	ger stated on 11/8/19, at 12:47 ware that the night nurse had egs last night and stated the have since RN-A had changed of ror R7's legs to be wrapped on 11/8/19, at 12:58 p.m. sitting lway with his legs not d, "They (nurses) probably 1/8/19, at 12:59 p.m. he had egs today and was planning on after he completed the	F 7		ICY)		
	have compression legs applied in the bedtime. R7's care venous ulcer on his						
	Director of Nursing	(DON) stated on 11/8/19 at					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	712/2010		
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F 725	1:02 p.m. R7 was oneurologist for righ nurses should follofollow resident care should have prefer DON stated staff his he had asked the nursing staff. DON wanted her to take trach on the transith him absolutely not of resident without acuity on the transith him absolutely not of resident without acuity on the transith him absolutely not of resident without acuity on the transith him absolutely not of resident without acuity on the transith him absolutely not of resident without acuity policy According independent well-being and according independent should assist residing and preferent Facility policy Self Participation dated resident should be with times of days. NA-J stated on 11/Hallway 200 did not a time. NA-J stated hallway 200 but three verything done the shift. NA-J stated hour NAs on a shift not getting toileted bathing and shower DON stated on 11/	diabetic and was seeing a t side numbness. DON stated w orders and staff should plans. DON stated residents ences and choices honored. ad been cut back this year and administrator to increase stated the administrator another new admission with a ion care unit and she had told could not admit that complex increasing staffing first as the ition care unit was high already. In maintaining and/or dent functioning, dignity and ommodate residents' individual nees. Determination and 7/25/16, indicated each allowed to choose schedules for treatments. 12/19, at 9:42 a.m. that thave enough NAs working at three were scheduled on the ewere not enough to get at needed to be done on a deallway 200 needed almost. NA-J stated residents were timely and were not getting ening completed at all.	F 7	25				
	nursing had not co	8/19, at 1:02 p.m. DON mpleted any audits to ponse time for long call light						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245304	B. WING		11	C / 12/2019		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 300 NORTH DOW STREET CANNON FALLS, MN 55009		712/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(X5) COMPLETION DATE			
F 725	Facility policy undindicated staff wor as soon as possib requests and need R15's face sheet in 11/26/18, with diagram dementia with behalf disorder, affective depressive disord (inappropriate involuments). R15's quarterly MI Brief Interview for had severe cognit 1-4 days during as supervision with beating. R15 requir dressing, toileting took an antipsychomedication daily. R15's Care Area Area and indicated R15 required to leave the R15 had severe counable to focus or recall what was satisfied to dementing the R15 was bothered independent with a Interventions including to the staff of the poter related to dementing the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was bothered independent with a Interventions including the R15 was better the R15 was bet	ents' request for staff ated, Answering the Call Light ald answer residents' call lights ale and respond to residents' ds. Indicated admission date of gnosis of Alzheimer's disease, navioral disturbance, anxiety mood disorder, major er, pseudobulbar affect coluntary laughing or crying) and DS dated 8/22/19, indicated Mental Status identified R15 ive impairment. R15 wandered sessment period, needed ed mobility, ambulation and ed extensive assistance with and personal hygiene. R15 otic, antidepressant and diuretic Assessment dated 12/7/18, uired a secured unit due to her ne facility and her memory loss. ognitive impairment and was n what others were saying and	F 7	725				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		11	C / 12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	712/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 725	and guide away frodocument any sign or others; Staff to bunit and keep R15 invade her personaneeded; Redirect vat risk for doing so distress; Monitor poccurrences. Review of Daily Sta 2019, revealed that staffed during day and the night shift Review of R15 res Vulnerable Adult (Vathat R15 had four a with physical aggre-On 7/27/19, R15 varound R57's neck in the arm before sindicated that consresidents and their everyone safe and On 9/19/19, R15 vansupervised when (LPN) heard screagot within eye sigh punching each oth indicated that the sthe time of the alteron 10/11/19, R55 near the exit door walk up behind R5 seen to get up from pushing R15 befor-On 10/22/19, R55	om source; Monitor and as of R15 posing danger to self be aware of R15 activity on the from residents that tend to al space; Cue and supervise as when R15 seems confused or mething that might cause acing, wandering or crying affing Sheets since July of the 300 memory unit was and evening shift with two staff one staff. Ident to resident altercations (A) - Incident reports revealed altercations since July 2019, ession with other residents. It was able to place her hands and then reach out to hit R56 staff could intervene. Report stant awareness of other behaviors was key to keeping secure. In and R55 were identified as an licensed practical nurse ming and swearing. When LPN the she found R15 and R55 er in the face. The report also second staff was off the unit at	F 72	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245304	B. WING _		11	C / 12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	712/2010	
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F 725	on 11/4/19, at 1:17 sitting at the table present. At 1:20 p. (LPN)-F entered the got up and walked room. The common three minutes whee on 11/4/19, at 5:20 sitting at a table yet table walked over the about a fist in yexactly what she so the walked over the about a fist in yexactly what she so the walked over the about a fist in yexactly what she so the walked over the about a fist in yexactly what she so the walking around an area where these two rekitchen staff entered by a direct care state unsupervised for formula of the walking around an area was an activity staff another resident be at 5:39 p.m., the acommon area where common area where common area where assisted the other returned to common area where the staff and the staff area to the s	then slapped him in the face I before staff could intervene. If person process the person process the person process to be for each process to be formulated by the person process the person process to be formulated by the person process	F 72	25			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	FALLS	ı	3	STREET ADDRESS, CITY, STATE, ZIP CODE 500 NORTH DOW STREET CANNON FALLS, MN 55009	1 11/	12/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	were unsupervised LPN-A left the com residents including staff arrived to com was unsupervised on 11/6/19, at 11:1 walking down the hanother resident ro in the common are visually see R15 ar On 11/7/19, at 7:51 with residents (including the other staff in a returned to the comunsupervised for fix On 11/8/19, at 7:58 to go into a residen including R15 unattarea and hallway. A of room to common unsupervised for si During interview on stated that R15 alwand someone need that the nurse had memory unit and thalone at times and everyone. NA-D states assistance with a rowho helped and veleft unsupervised do During interview on indicated monitorin	for eight minutes. At 8:22 a.m. mon area where there were R15. At 8:30 a.m., kitchen mon area. The common area for eight minutes. 3 a.m. R15 was observed allway and both staff were in om. There was an activity staff a but this staff was unable to ad her whereabouts. a.m. LPN-K left common area uding R15) present to assist room. At 7:56 a.m, LPN-K mon area having left the area we minutes. 5 a.m. both staff are observed to room leaving five residents tended within the common at 8:03 a.m. TMA-B came out a area that had been left x minutes. 1 11/4/19, at 5:25 p.m. NA-D mays had aggressive behaviors led to watch her. NA-D stated medications to give on the medications to give on the second that when she needs esident the nurse was the one rifies that the residents were	F 7	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245304	B. WING _		11	C / 12/2019	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 725	TMA-A stated "we residents when we and that was a safe. The activity director 11/6/19, at 10:20 a department did not memory unit. AD scalled to assist with memory unit while it was not part of the The assistant direction interviewed on 11/6 indicates that R15 she lashed out unpkept an eye on R15 be always in eye sistaff need to be in the common area asomeone to come, someone monitoring other residents with R15 continued to haltercations with now as unsure if anyonal altercation happen pattern. During interview or indicated R15 was on one to one superhave those resources.	cannot monitor all the are in getting residents up"	F 72	,			
	assistance and duradio call for assist the common area.	ring those times staff had to ance to monitor residents in DON stated it was her sidents were not left alone in					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245304	B. WING			1	C 12/2019
	PROVIDER OR SUPPLIER			300 NO	ADDRESS, CITY, STATE, ZIP CODE RTH DOW STREET DN FALLS, MN 55009	1 11/	12/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE ROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	On 11/6/19, at 2:09 should have always view of the hall and stated there were to the nurse went to go carried radios so the On 11/7/19, at 8:45 stated staff were existed staff were existed was in the common area at all know what they will review of undated Altercation policy in	p.m. RN-A indicated there is been one staff within eyes documen area ideally. RN-A imes that did not happen as give pills but that was why staff arey can ask for help. is a.m. licensed social worker expected to be with R15 when amon area. is p.m. NA-I stated someone esidents when they were in the I times because "you never I do." Resident to Resident lentified staff were to monitor ssive or inappropriate	F 7	25			
	Procedure indicate measures to addre minimize the possil Prevention Prograr committed to prote policy also indicate and patterns of pot changes to prevent Nurse Aide Peform CFR(s): 483.35(d)(7) Regulation (Section 1988).	d staff were to institute ss the needs of residents to bility of abuse. The Abuse in section indicated staff were ct residents from abuse. The d staff will identify occurrences ential abuse and implement a future occurrences. Review-12 hr/yr In-Service 7) ular in-service education. complete a performance review at least once every 12 provide regular in-service	F 7	30			12/29/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245304	B. WING		11/1	2/2019
	PROVIDER OR SUPPLIER	FALLS	:	STREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 730	education based or reviews. In-service requirements of §4: This REQUIREMENT by: Based on observative review, the facility frevaluations were consistents (E1, E2, facility for over a yellow facility for over a yellow facility for over a yellow facility over a year. of 10/27/14. E1's persof 10/27/14. E1's persof 10/27/14. E1's persof 10/27/14. E2's persof 3/23/18. E2's persof 3/23/18. E2's persof 3/23/18. E2's persof 3/23/18. E2's persof 5/19/17. E3's persof 5/19/17. E3/19/17. E3/19/17. E3/19/17. E3/19/17. E3/19/17. E3/19/17.	training must comply with the training must comply with the 33.95(g). NT is not met as evidenced tion, interview and document ailed to ensure performance ompleted for 3 of 5 nursing E3) who had worked at the ar. sonnel file revealed a hire date ersonnel file revealed E1 was (NA) who had worked at the E1's file revealed no evidence valuation (PE) completed. sonnel file revealed a hire date ersonnel file revealed E2 was a dat the facility over a year. To evidence of a PE completed. sonnel file revealed E3 was a dat the facility over a year. To evidence of a PE completed. the Human Resources tor (SD) on 11/12/19, at 10:39 and there were no PEs in E1's, onnel files. HR/SD stated is PE's were "overdue" and	F 730	1.It is the expectation that annual performance evaluations are to be on all employees. 2.Performance evaluations will be of for the nursing staff by 12/29/2019. 3.This has the potential to affect all residents 4.The director of nursing or designed be responsible for compliance. Aud be done weekly x 2 months and the monthly x 1. Results will be reviewed our Quality committee for further recommendation.	current I facility ee will dits will en	
	·	sted from the facility and not				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING			COMPLETED	
		245304	B. WING			11/1	C I 2/2019	
	PROVIDER OR SUPPLIER	FALLS		30	TREET ADDRESS, CITY, STATE, ZIP CODE ON NORTH DOW STREET ANNON FALLS, MN 55009	117	12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
F 740 F 740 SS=D	Behavioral Health SCFR(s): 483.40 §483.40 Behavioral Each resident must provide the necess services to attain of practicable physical well-being, in accordance assessment and plencompasses a resident well-being, limited to, the preveand substance use This REQUIREMED by: Based on observative review, the facility fassess and developersident to resident (R43, R27) reviewed altercation. Findings include: R43 was observed seated in his w/c calculated and state threatened him who air and yelled at hir threatened him, the	I health services. It receive and the facility must ary behavioral health care and maintain the highest and mental, and psychosocial redance with the comprehensive an of care. Behavioral health sident's whole emotional and which includes, but is not ention and treatment of mental disorders. No is not met as evidenced atton, interview and document failed to comprehensively printerventions regarding to behaviors for 2 of 2 residents and for resident to resident and alert. R43 was atted about a month ago R27 and R27 held his cane into the m. R43 stated after R27 are facility still had R43 and R27	F 74		1.We completed mood and behavior assessments for both residents R27 R43. their care plans were reviewed a updated to reflect current intervention mood and behaviors. 2.This has a potential to affect all residents in our facility. All current residents have been reviewed for cur mood and behavior assessments and reassessed as needed. Care plans reviewed and updated to reflect currer mood and behavior needs. 3.Social service director and all nursing staff were in serviced on the facility promood and behavior assessments	and and ns for rrent d ent ing solicy	12/29/19	
	expressed concern services (DSS). R4 and R27 became ro about R43's TV hav R43 was seated in attempted to hit hin	s roommates despite R43's as to the director of social 3 explained shortly after he commates R27 was upset ving been too loud and while his wheelchair (w/c) R27 in with his cane in his head. to cover his head. R43 stated			interventions on 12/20/2019, 4.Social service director or designee be responsible for compliance. Audits be completed weekly x 4, then month 2. Results will be reviewed by our Qu committee for further recommendation	s will nly x ıality		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C		
		245304	B. WING _		11	/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 740	he sustained a lace cane. R43 stated a moved to a new room. Family member (FI telephone on 11/5/R43 was not getting and indicated R43 another resident which stated the facility stated the facility stated the facility stated with it." R27 was interviewed stated R43 made a accusing R27 of his threatening him. R2 been threatened by the director of nurse threats, however sawas observed seath his cane near the whe would sleep with FM-A was interview at 9:44 a.m. and state and R27 had to slebeen "afraid of other	eration to his hand from R27's fter R27 hit him R43 was om. M)-B was interviewed via 19, at 10:33 a.m. and stated g along with other residents had to call the police due to nom hit R43 with a cane. FM-B aff would tell her R43 was the id was told by the facility staff ed on 11/6/19, at 1:07 p.m. and false allegation against R27 ting R43 with his cane and 27 stated it was him whom had a R43. R27 stated he notified ing (DON) regarding R43's aid nothing had changed. R27 ed on the edge of his bed with wall of the bed. R27 indicated in his cane in his bed. Wed via telephone on 11/8/19, ated R27 called her last d "he was in fear for his life" ep in the chapel due to having ers." FM-A indicated she came	F 74	*			
	beer due to R27 ha	e weekend and brought R27 a aving been a "chronic alcoholic lot of street drugs in his day." ought R27 would do better if ast daily.					
	10/3/19, identified I diagnoses which in	num Data Set (MDS) dated R43 had intact cognition and cluded anxiety and nual MDS indicated R43 had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION	СОМІ	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	FALLS		300	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH DOW STREET ANNON FALLS, MN 55009	<u>, 117</u>	12/2013
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 740	verbal behavioral so others one to three period and indicate did not impact other R43's Cognitive Loc (CAA) dated 10/15/guardian due to por R43 made poor der R43's Mood State (R43's Mood State (R43's Mould try to ge and would adjust to Behavioral Sympto indicated R43 would R43's Care Plan rewas intolerant of renot demonstrate bevalues and directed make own decision between resident a environment, provio participate in care, identify problems the potential solutions to conflict arises remove environment and al R43's Admission R R43 had diagnoses disorder with mixed opioid abuse and proposed for the PN dated 9/20 extreme outburst" as	ymptoms directed toward days during the reference d R43's behavioral symptoms	F 7	40			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245304	B. WING		11	C / 12/2019	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009				
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F 740	writer and the LSW unable to calm him had no choice but indicated when the calmed down and -The PN dated 9/2 another resident w "profanity during di dining room shouti able to redirect; -The PN dated 9/2 roommate a questi "to F*** offwriter out of line. Roomm while" R43 stayed -The PN dated 9/2 a room change not full seven days bef -The PN dated 9/2 roommate yelled a intervened as soor "Resident is very a -The PN dated 10/ was upset R43 had think this was fair. had three roomma a respectful manne -The PN dated 10/ swing out at staff a hallway then fell as -The PN dated 10/ 9/27/19," and ident room as soon as y the room R43 indic remove R43 was fi roommate was sea indicated R43 had stated his roomma	I [licensed social worker] were a down. I informed him that I to call the police." The PN police arrived R43 had apologized for his behavior; 1/19, indicated R43 and ere arguing and used nner" both parties were in the ng at each other "writer" was 5/19, indicated R43 asked his ion and his roommate told R43 told both residents they were nate went back into the facility outside; 6/19, indicated R43 was issued diffication guardian requested a fore moving R43; 7/19, indicated R43 and the each other in their room, staff in as yelling was heard. Indicated R43 guardian did to move again and did not the facility indicated R43 had the sand had not treated them in er; 7/19, indicated R43 "started" to and wheeled self into the	F 740				

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED C	
245304	B. WING		11	/ 12/2019	
		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
e was laying next to the wall on vacy curtain pulled between 0/13/19, indicated suspicion of d marijuana paraphernalia had 843 confirmed that he used it; 0/31/19, indicated R43 was ass" R27. R43 started to make when R43 and R27 were releft room to let R43 calm down led. Cord lacked evidence of ssessment, development of ongoing monitoring of sues with other residents. S dated 9/9/19, identified R27 on and diagnosis which included mual MDS indicated R27 had no lons during the reference period. It R27 had a new roommate it. Tevised on 10/14/19, identified social wellbeing problem related by to problem solve, social cated staff to encourage R27 to make own decisions, lurage realistic goals, when nove R27 to a calm safe					
	A FALLS TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) Dage 111 The was laying next to the wall on wacy curtain pulled between Double of the wall and the used it; Double of the wall and the wall and the used it; Double of the wall and the wall and the used it; Double of the wall and the wall and the used it; Double of the wall and the wall and the used it; Double of the wall and the wa	245304 R N FALLS TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) PREFIX TAG TAG TAG TAG TAG TAG TAG TAG	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY PULL RUSC IDENTIFYING INFORMATION) PRESIX TAG TAG TAG TAG TAG TAG TAG TAG	R NFALLS TATEMENT OF DEFICIENCIES O'MUST BE PRECEDED BY FULL TAG Was alaying next to the wall on vacy curtain pulled between 10/13/19, indicated suspicion of d'marijuana paraphernalia had k43 confirmed that he used it; 10/3/11/9, indicated R27 were refer to more to the R43 calm down led. 2007 alacked evidence of ssessment, development of ongoing monitoring of sues with other residents. S' dated 9/9/19, identified R27 on and diagnosis which included nural MDS indicated R27 had no oms during the reference period. Italian Well-Being CAA dated at R27 had a new roommate to the revised on 10/14/19, identified social wellbeing problem related yto problem solve, social cted staff to encourage R27 to make own decisions, urage realistic goals, when nove R27 to a calm safe	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		11	C / 12/2019	
	PROVIDER OR SUPPLIER			11212013			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 740	Continued From page	age 112	F 74	0			
	from dangerous sit confused or at risk cause distress.	cally to ensure safety, remove tuations and redirect when for doing something that might					
		Record dated 11/8/19, indicated sis of alcohol abuse.					
	11/7/19, and reveal -The PN dated 9/1 his roommate becatowards him and for R27 was moved to -The PN dated 9/2 a new room and wadjusting to each of -The PN dated 9/2 roommate were year of want to stay the -The PN dated 10/9/27/19, yelling was and upon enter the very agitated and hit him with his carcane was lying new	7/19, indicated R27 reported ame verbally aggressive rels unsafe in current room. To a new room; 5/19, indicated R27 moved into ras having had "difficulties" rother; 7/19, indicated R27 and his relling at each other and R27 did red due to not trusting him; 10/19, indicated "Late entry for sheard from residents room re room R27's roommate was R27's roommate indicated R27 re. The PN indicated R27's ct to the wall on his bed with the red ween and "writer does not"					
	-The PN dated 10/ "short tempered w -The PN dated 10/ he had a verbal alt roommate. A subs indicated R27 shown hall towards staff a roommate had an indicated R27 was way and was enco	12/19, indicated R27 was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245304	B. WING		11	C / 12/2019	
	NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS			STREET ADDRESS, CITY, STATE, ZIP 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 740	would take his car way;" -The PN dated 11 lying on the floor or roommate having indicating "they we names. The PN ir return to his room areas of the facilit The PN indicated were notified of in-The PN dated 11 chapel "again" anhis room, howeve staff. R27 encoura however R27 dec subsequent PN dated 11 R27 was found seconfused and parnot going back int was not there. R2 different room and R43's medical recomprehensive as interventions and behaviors and iss DSS was interview and stated R43 ar the building and the and R27 had a veindicated she talk about the need to	ne and hit anyone who got in his /1/19, indicated R27 was found of the chapel due to his "physically threatened" R27 ould beatme" and called R27 idicated R27 did not want to and remained in common y for the rest of the overnight. the DON and nurse manager	F 7	740			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING _			C / 12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 740	not "seem to get al that R43 accused I cane, however did The DSS further ex roommates he did R27 had roommate DSS stated R27 hat that he had issues in the chapel due to the c	ong." The DSS stated after R27 of hitting him with his not think the incident occurred. Aplained R43 had previous not get along with as well as a issue prior to R43 and after. Ad a new roommate after R43 with as well and was sleeping to the issues. NA)-A was interviewed on m. and stated R27 had a ation with his roommates and ad leave his room and refuse to when he felt threatened. NUTSE (LPN)-B was interviewed a.m. and stated she had been R43 accused R27 of hitting him the TV. LPN-B stated she refused a yelling back and forth, le to verify if R27 did or did not ne. RN)-A was interviewed on m. and reviewed R43's and not verified both care plans ollowing behaviors and issues as RN-A confirmed R43's care ce of possible substance use. Area on 11/8/19, at 12:14 p.m. er expectation to re-evaluate ident's care plan when there e in behavior and/ or continued	F 74	40			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING		1	C 1/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		1/12/2013	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUTH CORSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 740	associated with the impaired behavior. appropriate assess behavioral symptom between behavioral managed by treating that cannot. The possible comprehensive assible based on input from caregivers, review cobservations which typical or past responsively, frustration nursing staff would precipitating or releinterdisciplinary teal evaluate new or chain order to identify any modifiable factor to the resident's chaplan would incorpor comprehensive assistent with currinterventions would an overall care envithe residents distreprogress of the indicand interventions wimpact on behavior	we had minimal complications management of altered or The policy indicated ment and treatment of ins required differentiating a symptoms that could be gunderlying factors and those dicy indicated part of the dessment staff would evaluate in the resident, family and of medical record and general would include resident's conses to stress, fatigue, fear, and other triggers. The identify and document any want factors. The m (IDT) would thoroughly anging behavioral symptoms underlying causes and address for that may have contributed ange in condition. The care rate findings from the dessment which would be sent standards of practice. The individualized and part of fironment to prevent or relive ses. The IDT would monitor the viduals behavior until stable rould be adjusted based on the	F 7				
F 744 SS=D	§483.40(b)(3) A residiagnosed with den appropriate treatme	sident who displays or is nentia, receives the ent and services to attain or highest practicable physical,	F 7	44		12/29/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG	СОМ	(X3) DATE SURVEY COMPLETED	
		245304	B. WING _			C 12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET	•		
				CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 744	Continued From pa	age 116	F 7	44			
	This REQUIREME	NT is not met as evidenced					
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dementia services were provided including implementation of personalized behavioral interventions and failure to reassess the effectiveness of interventions for 1 of 4 residents (R41) reviewed for dementia care. Findings include: The Director of Nursing (DON), Assistant Director of Nursing (ADON) and nursing assistant (NA-B) were interviewed on 11/5/19, at 5:06 p.m NA-B stated about a week ago NA-B observed LPN-A			1.Nursing and Social Service reassess resident for psychological and add personalized behavior interventions to minimize the is displayed during cares. Rewill be included in intervention care plan. Nursing and Social will reassess residents that to behaviors to ensure personal behavioral interventions are 2.This has the potential to all residents. All current residents reviewed for current mood, it psychosocial assessments as	osocial needs vioral e anxiety that 41 and family ons on the al Services display alized in place. ffect all facility ints have been behavior and		
	"being physical" ar explained R41 was LPN-A continued of R41 was "begging R41 repeatedly ye alone" as R41 tigh however NA-B indivated LP changing R41 out both LPN-A and N R41 while "pulling DON explained R4 resistive to cares, time and reapproar R41's quarterly Mil 8/26/19, identified impairment and dia dementia and Park quarterly MDS indistaff assistance wi (ADL). The MDS for R41 was supposed to the resistive to cares, time and reapproar R41's quarterly Mil 8/26/19, identified impairment and dia dementia and Park quarterly MDS indistaff assistance wi (ADL). The MDS for R41 was "begging as a supposed to the resistive to cares, time and reapproar R41's quarterly Mil 8/26/19, identified impairment and dia dementia and Park quarterly MDS indistaff assistance wi (ADL). The MDS for R41 was "begging R41 tight however NA-B individual tight h	nd "rough" with R41. NA-B is asking not to be touched and on and "man handled" R41 as not to touch" her. NA-B stated led "leave me alone leave me tened her arms inward, icated LPN-A did not stop. N-A asked NA-D to assist with of urine soaked clothing and A-D continued "manhandling" her clothes off against her will." It had a history of having been however staff were to give R41		reassessed as needed. Care reviewed and updated to refi mood, behavior and psychos 3. Nursing Staff, licensed sociand MDS Coordinator will be education on personalized biglan interventions 4. The director of nursing or obe responsible for compliant be done daily x 4 weeks the Results will be reviewed by committee for further recom	e plans lect current social needs. cial worker e provided behavior care designee will ce. Audits will n monthly x 2. cur Quality		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C	
	245304	B. WING		11	/12/2019	
NAME OF PROVIDER OR SUPPLIE THE GARDENS AT CANNO			STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET CANNON FALLS, MN 55009		112/2010	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
R41's Cognitive I Assessment (CA thought staff wer wishes" her husb directed staff to acceptance and Behavioral Sympidentified R41 ha understand staff would refuse to le indicated R41 wo with her cares. R41's Care Plan was dependent of emotional needs to one's as R41 I enjoyed being restaff to converse and encourage faplan revised 9/9/to hit others and address contribu R41 became agif guide away from calmly in converse aggressive staff to R41 tolerates two one foot of person touch by telling sfurther identified problem and direneeds, allow ade	page 117 Interest of three days. Loss/Dementia Care Area A) dated 6/3/19, identified R41 e trying to hurt her and "only and care for her. R41's CAA continue to work with R41 to gain help R41 with ADLs. R41's toms CAA dated 6/3/19, d dementia and did not were trying to help and R41 et staff help her. The CAA huld adjust to staff helping her dated 5/31/19, identified R41 in staff for meeting physical and and R41 would benefit from one oved to talk of her grandson and ad to. R41's care plan directed with R41 while providing cares amily involvement. R41's care 19, identified R41 had potential directed staff to assess and ting sensory deficits and when eated intervene before escalates, source of distress, engage sation, if response was were to walk calmly away and he care plan identified R41 get out and directed staff that to people at a time and provide nal space and R41 reacted to taff to get away. The care plan R41 had communication cted staff to anticipate and meet quate time to respond, repeat as t rush, request clarification from	F 74	1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING				C 12/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET CANNON FALLS, MN 55009	ODE		12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 744	speaking, make e environmental noi simple brief consist R41 and family co-communication dit thoughts focus on sense, monitor/ do seconds prior to post validate R41's medicate R41's medicate R41's medicate R41's medicate R41's medicate R41's medicate R41 refused bedtime cares from attempted R41 refused bedtime tillustrate PN dated 10 morning medication. The PN dated 10 be toileted by staff to toilet her. R41's medical recomprehensive reand current effection behavior intervent R41 was interview was unable to ansign R41 was observed assisted with morn Registered nurse	ye contact, reduce se, as yes/no questions, use stent words/ cues, discuss with incerns regarding ficulty, encourage R41 to state a word or phrase that makes ocument frustration level wait 30 roviding R41 with word and ssage by repeating aloud. Otes (PN) were reviewed 11/6/19, and revealed the 1/12/19, indicated R41 refused to 1/16/19, indicated R41 refused in her husband and when staff fused several times, R41 also me medications as well; 1/26/19, indicated R41 refused ons after three attempts; 1/31/19, indicated R41 refused to and "eventually" allowed staff ord lacked evidence of assessment of R41's behaviors veness of current personalized it in bed eyes open mumbling to	F 7	'44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _		11	/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP O 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 744	assisted R41 to sit placed slippers as "oh come on now, NA-C placed trans moved R41's walke independently begawalker as she controme on, oh God rwalk into the bathronto the toilet. NA-with one hand each assisted R41 to stand stated R41 wand stated R41 was sist and ensure and during these tistatements. LPN-A was interviewed the statements. LPN-A was interviewed the statements.	in the edge of her bed and R41 sat on the bed R41 stated oh God no oh come on now" fer belt around R41 and RN-A er in front of her. R41 an to place her hands onto the inued to repeat "oh God no, no." RN-A verbally cued R41 to com and offered R41 to sit C and RN-A stood near R41 n on R41's transfer belt and and R41 walked with walker	F 74	4			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		245304	B. WING _			C 1 2/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	,	12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 744	complaining she was wanting to get back "usually" you just re however sometime stated she was foccold and was work her out of the wet of LPN-A stated she and positioned R41 DON was interview and stated it was her follow the resident monitor the effective update the care plate of the facility Demensing function indicated for individual interdisciplinary tear resident-centered or remaining function indicated IDT would overall plan dependence of the facility of the facility of the facility Demensing function indicated IDT would overall plan dependence of the facility of the facility Demensional function indicated indicate	R41 was resistive and as cold and was yelling due to a into bed. LPN-A stated eapproach R41 and try again, so that did not work. LPN-A used that R41 was wet and ing to keep R41 warm and get elothing and back into bed. and the NA continued to work a back into bed. Ted on 11/8/19, at 12:21 p.m. wer expectation staff were to care plan, evaluate and reness of interventions and	F 74	4			
F 755 SS=E	CFR(s): 483.45(a)(§483.45 Pharmacy The facility must pr drugs and biologica them under an agre §483.70(g). The fa personnel to admir		F 75	5		12/29/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED C		
		245304	B. WING _			12/2019	
	PROVIDER OR SUPPLIER	FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			11/12/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 755	pharmaceutical ser that assure the acc dispensing, and ad biologicals) to mee §483.45(b) Service must employ or ob pharmacist who- §483.45(b)(1) Provaspects of the provathe facility. §483.45(b)(2) Estareceipt and disposis sufficient detail to ereconciliation; and §483.45(b)(3) Deteorder and that an ais maintained and parties REQUIREME by: Based on observareview, the facility finarcotic document. R26, R36, R45, R5 facility failed to enserconciliation of na during October and the facility failed to reconciled and desidocumentation ma	ures. A facility must provide rvices (including procedures curate acquiring, receiving, ministering of all drugs and t the needs of each resident. • Consultation. The facility tain the services of a licensed rides consultation on all rision of pharmacy services in blishes a system of records of tion of all controlled drugs in	F 75	1.R23, R25, R26, R36, R45 a have a comprehensive record comparison of the EMR to the narcotic book. Missed doses we medication error report filled of cause analysis will be done to determine the cause of inaccunarcotic documentation. The rare expected to count at the band end of their shift to ensure controlled substances are accontrolled.	review with bound will have out. A root help trate nursing staff eginning e all		
	Findings include:			R32 is deceased. The missing morphine were reported on the			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 755	R23 R23's Minimum D diagnoses that incher right leg and h impairment. R23's medication indicated R23 was hydrocodone-aced (mgs) every six ho On 10/23/19, R23 signed out by nurs book for R23, how documented in R2 doses were signe dated 10/24/19, ic dose. The next th narcotic log were scheduled doses 7:00 p.m. It appea 10/24/19, was dat the 2:00 a.m. dos discrepancies wer nurse (LPN)-D du 10:12 a.m. and by on 11/8/19. R25 R25's MDS dated that included fract disease, cirrhosis was cognitively in R25's MAR indicat oxycodone every	ata Set (MDS) identified cluded lymphedema and pain in had significant cognitive administration record (MAR) a prescribed taminophen 5-325 milligrams ours for pain. had three doses of oxycodone sing staff in the narcotic sign-out wever four doses were 23's MAR. On 10/24/19, five dout with the fifth (last) dose lentified as being the 2:00 a.m. ree doses signed out in the dated 10/25/19, for the usually for 7:00 a.m., 1:00 p.m., and ared the fifth dose signed out on ed incorrectly and was actually a for 10/25/19. These re verified by licensed practical ring an interview on 11/8/19, at the director of nursing (DON) 9/11/19, identified diagnoses were in left foot, end stage liver, and ascites. It indicated R25 tact.	F 7	Home Incident Reporting Falls Police Department came to the facility to invistaff have been interview medications are unaccount morphine and 8 ml of moderation and 9 ml of moderation	was notified and estigate. Nursing yed. The unted for (1 ml of orphine). o affect all facility dication for yiewed to ensure d accounted for. ded on including the g, receiving, on and substances, ents in the EMR, ure book was done at each 19 or designee will iance. Audits will weekly x 1 Results will be committee for		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 300 NORTH DOW STREET CANNON FALLS, MN 55009		712/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 755	doses were docur discrepancy was winterview on 11/12 R26 R26 resided on a diagnoses including pain, and unspeciadmission record Per physician ordereceive the medic pain medication) finalm. On 11/12/19, at 00 administration tracreviewed with Track discrepancy approved administration tracreviewed with Track discrepancy approved administered not been registered on further investig cards of pills and documentation, or R36 R36's provider ordindicated diagnos syndrome, persist several pressure summary indicate oxycodone 15 mg pain. On 10/16/19, two entered into the next several pressure of the pain.	e sign-out book, however, two mented in R25's MAR. This verified by LPN-E during an 2/19. secured memory unit with any arthritis of the knee, low back ified pain, according to dated 7/10/18. ers dated 11/12/19, R26 was to eation oxycodone (a narcotic five mgs four times per day for 9:19 a.m. the required narcotic cking book for R26 was ined Medication Aide (TMA)-A. peared to exist when it was ed scheduled medications had ed in the narcotic sign-out book. gation, R26 had 2 separate 2 separate pages for ne page for each card of pills. der summary printed 11/12/19, es included chronic pain tent fracture of left humerus, ulcers, and quadriplegia. The ed R36 was prescribed gevery four hours for chronic doses of oxycodone were arcotic sign-out book, but four	F 7	755		
	doses were docur with two doses we	mented as given in R36's MAR ere blank. On 10/17/19, the 4:00				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245304	B. WING _		11	/12/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 755	p.m. and 10:00 p.r there were three d 6:00 p.m., and 10: doses left blank. Osigned out and all documented in the During an interview LPN-E verified all records. R45 R45's MAR indicate oxycodone five monarcotic log two tindoses were documented these disconn 11/8/19, at 9:24 R51 R51's MAR indicate hydromorphone or chronic respiratory 10/14/19, and 10/10 out in the narcotic were documented and 10/17/19, five doses were entereverified these disconn 11/8/19, at 9:24 The three current were reviewed on accurate practice if	m. doses were signed out, but oses documented at 4:00 p.m., 00 p.m There were three On 10/19/19, four doses were six scheduled doses in both ded R45 was prescribed gos three times per day. On 11/6/19, and 11/7/19, R45 had godoses signed out of the mes each day. However, three mented in R45's MAR for each director of nursing (DON) repancies during an interview dia.m Ited R51 was prescribed me mg every four hours for a failure with hypoxia. On 15/19, four doses were signed sign-out book, but six doses in R51's MAR. On 10/16/19, doses were signed out and six and in the MAR. The DON repancies during an interview	F 75	55		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		245304	B. WING		11/1	: 2/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	,	2/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 755	signatures. The na showed from 10:00 on 9/28/19, totaling signatures for 40 ha.m. on 10/18/19, were no signatures reconciliation was DON verified these narcotic count on indicated it was the be counted at the example of the administrator at 12:40 p.m. and audits of narcotic undicated it was the on 11/12/19, at 2:5 aware of the narcotic any specifics. CP is quarterly quality concept quarterly and is soft stated narcotics we were required to have only two months concept to the consultant that the region of the phase of th	procotic log for station 300 p.m. on 9/27/19, to 2:00 p.m. og 40 hours, there were no lours. Additionally, from 6:00 to 10:00 p.m. on 10/9/19, there is indicating narcotic medication completed. The missing signatures on the 11/8/19, at 9:45 a.m. and a expectation that they should	F 75			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		ı	C / 12/2019
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F 755	had intact cognition included anxiety, a pulmonary disease annual MDS indicated received opioid several services of pulmonary disease annual MDS indicated received opioid several services opioid several several services opioid several sev	dated 9/19/19, indicated R32 in and diagnoses which sthma, chronic obstructive or chronic lung disease. The ted R32 had frequent pain and iven out of seven days. The real real real real real real real rea	F 75	5		
		ewed on 11/12/19, at 10:16				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	IPLE CONSTRUCTION IG	COMPLETED	
		245304	B. WING_		11	/12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		712/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 755	morphine sulfate d 10/31/19, with 1.00 she was unsure wh 10/31/19, regarding sulfate. DON was interview and verified R32's with 1.00 ml and 8 explained LPN-D oper their policy who morning. DON state "thrown away," how happened with the not have any medifile. DON stated it narcotics were recommored to the consultant phatelephone on 11/12 per the board of phatelephone	ated 5/17/19, with 8.00 ml and ml remaining. LPN-D stated at happened from 10/26/19, to g R32's 4.75 ml of morphine are don't 12/19, at 12:22 p.m. two bottles of morphine sulfate 00 ml were "missing." DON lid not count those two bottles on she started her shift that es she suspected the 1 ml was ever was unsure about what 8.00 ml. DON verified R32 did cation disposition records on was her expectation that all conciled at every shift change. Armacist was interviewed via 2/19, at 2:57 p.m. and stated for the facility destroy narcotics per trail" should have been	F 78	,		
	controlled medicate the nurse coming of duty must make the investigate any discretonciliation to de the pharmacy and needed legal action	cons at the end of each shift, on duty and the nurse going off e count together. DON would crepancies in narcotic termine the cause and consult administrator to determine any n. The facility Discarding and tions policy adopted 8/12/19.				

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		245304	B. WING _		11/1	; 2/2019
	ROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
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F 755 F 835 SS=F	accordance with feed. The policy indicated substances would be locked area with rest of. The policy indicated substances must have no longer than three Following medication record would include method and witness disposition record work for two years. Administration CFR(s): 483.70	ns would be disposed in deral and state regulations. It all unused controlled be retained in a securely stricted access until disposed ated disposal of controlled ave taken place immediately e days after discontinued. On destruction a disposition be reason for disposition, as signature. The medication would have been kept on file	F 75			12/29/19
	enables it to use its efficiently to attain of practicable physical well-being of each in This REQUIREMENT by: Based on observation review, the facility fawas managing facility resident needs were sufficient staffing ratighest practicable and well-being. This potential to affect at the facility. Findings include: On 11/6/19, at 1:28	dministered in a manner that resources effectively and or maintain the highest l, mental, and psychosocial		1.It is facility policy to ensure we ar utilizing facility resources with responsibility resident staffing ratios to promote resident's highest practicable physical mental function and well-being. 2.This has the potential to affect all residents in our facility. 3.The facility has reviewed the facil assessment to ensure we have sufficient to meet the needs of our reon 12/18/2019. We reviewed acuity ensure or staffing was sufficient 4.The administrator or designee will to ensure compliance with sufficient	ect to the cal and ity ficient esidents to	

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		245304	B. WING		C 11/12/2019	
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F 835	council function. The and provided the form and provided the form and provided the form and to wait a long that and to wait a long that and to wait a long that and the follow-up with our ordered and the follow-up with and couple of months; -R37 stated wait the follow-up with times he would not enough staff; -R15 stated there wilght response and not always able to regarding getting underted and residents felt in their call light without providing the minutes dated regarding call lights times and call light without providing the The minutes dated and the minutes dated and call lights without providing the minutes dated and the minutes da	ne following residents attended bllowing information: ng gets fixed" here we have sime for call lights to get r nobody did anything to concern; nts had to wait a long time for swered; nd to wait a long time for staff icated if you were in your room you would have to wait even I light to be answered. R18 gotten worse over the past the past few months and at a get showers due to not were long wait times for call indicated due to this staff were accommodate his choice	F 835	staffing. Audits will be cor 1-month, weekly x 4, then Results will be reviewed be committee for further reco	n monthly x 1. by our Quality	

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F 835	average 45 minuter minutes indicated turned off without a minutes further incomplete there was not enough baths were not being. The minutes date were frustrated regfeeling as nothing long call lights; The minutes date residents and five still no follow up or The minutes date expressed regarding long call. The resident countresponse letters larelated to continue wait times. The ombudsman (11/6/19, at 1:37 p. repeated staffing is residents complain to meet their care reached out to the week ago regardin had not received at 2:18 p.m. and very was responsible to concern from residents concern from residents using the survey.	es to one hour wait time. The call lights were still being assisting the resident. The dicated they were being told ugh staff and showers and/ or ng completed; d 7/31/19, indicated residents garding no resolution and was being done regarding the d 10/10/19, indicated 20 staff were in attendance and a long call light wait times; d 10/30/19, indicated concerns ng not enough staff during the still waiting for a response lights wait times. cil meeting minutes and cked evidence of follow-up and concerns of long call light OMB) was interviewed on m. and stated there was not enough staff needs and indicated the OMB director of nursing (DON) a gethese concerns, however a response. was interviewed on 11/12/19, erified each department head of follow up on each identified	F 83				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 835	Continued From pa	age 131	F 83	5		
	document review, the accommodate residual of 2 residents (Residents of Accomment review, the timely toileting assisted (R44) and weekly stresidents (R43) where activities of daily living the second of the second	dent preference for bedtime for 46) reviewed for choices. on observation, interview and the facility failed to provide stance for 1 of 5 residents shower assistance for 1 of 5 o needed assistance with ring (ADLs).				
	sufficient staff were needs for 4 of 5 residependent on staff and for 5 of 9 resid R51) whom express council meeting. In provide supervision	the facility failed to ensure available to meet resident sidents (R44, R43, R46, R7) for activities of daily (ADLs) ents (R24, R12, R18, R37, sed concerns during resident addition, the facility failed to a to reduce resident to resident f 5 residents (R15, R33, R55, emory unit.				
	indicated the asses what resources we residents competed operations and emscheduled to ensure meet the needs of and further indicate based on census a appropriate support assessment indicate have had a 1:11 1:14 ratio during over the support of t	sment reviewed 9/19/19, sment was used to determine re necessary to care for the ntly during both day to day ergencies. Staff were se sufficient staff were able to the residents at any given time ed staff patterns were adjusted nd acuity levels while providing t for the residents. The ted direct care staff- NA were ratio on days/ evenings and vernights in long term care.				

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F 835	overnight there wan urses. Furthermo assistance with acconjunction to the included transfer a resident range 1-2 residents 1-20 and 1-20 and behaviors 1-20. The staffing directed 11/8/19, at 9:01 and staff one NA on the 200 unit and one Nourse per unit on covernight shift there one nurse for the 1200 and 300 unit. It the following staffing were reviewed 10/ revealed the follow -On 10/4/19, the set two NAs on the 20	s to have been 1:50 ratio for re, the assessment identified tivities of daily living in identified staffing ratios ssistance for an independent 6, one to two staff range of dependent resident range all health needs resident range of the later of the later of the later of l	F 83	,		
	a.m. until 6:00 a.m the 200 and 300 unurse, SD verified 1:33 to 40; -On 10/18/19, the shift was "short" or verified the NA rati-On 10/20/19, the sovernight shift ther facility. The posted SD verified census indicated the nurse-On 11/2/19, the so-	schedule indicated from 4:00. the 200 unit NA covered both nit with assistance from the the NA ratio would have been schedule indicated the evening ne NA on the 200 unit, SD o would have been 1:15 to 16; schedule indicated during the e was only one nurse for the staff hours were reviewed and was 57 on 10/20/19, which				

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F 835	NAs in the facility. reviewed and SD v 11/2/19; -On 11/8/19, the so day shift there were with a current cens 1:15 to 16. The DON was interp.m. and stated sta and she asked the nursing staff, howe administrator's resistated the administrator's resistated the administrator and the transition castaff would need to The administrator and 11/8/19, at 1:33 p.r the facility assessing the state of th	The posted staff hours were rerified census was 53 on chedule indicated during the end only two NA's on the 200 unit rous of 31 which indicated a cryiewed on 11/8/19, at 1:02 of had been cut back this year administrator to increase over the DON indicated the ponse was no. The DON crator wanted to take a new each on the transition care unit, im absolutely not due to the resident considering the acuity are unit was high already and	F8	35			
	administrator verification there were call in's been around 1:12.7 administrator explain on acuity and indication was 0.9 which was was below their go. The administrator is staff based on acuity would need have buring interview with 11/12/19, at 4:32 p. QAPI meetings and	ed on most days and when the staffing ratio would have					

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F 835	get staff response discussion had bee wait time and staffi probably staffing no could be improved of any call light wai. The administrator a 11/12/19, at 12:48 six to eight months the 200 unit with or nurse; on the 100 u and on the 300 unit administrator indicastaff in the building per patient per day indicated during that they couldn't do it a The administrator i made by himself an nurse to also care unit. The administrator is if the staff were complaining about and indicated due to staff "it's really toug to say" the facility weight months. The 2/2019, the facility decreased staff by one NA on the 300 "we were aware the unhappy with the sadministrator explain the directive from hederease the staffi staff, however the able to get the Chief	for assistance. MD stated on made regarding call lighting. MD stated, "It was not quite meeting the ratio and "MD stated he was not aware time audits being completed. and DON were interviewed on p.m. The administrator stated ago the facility was staffed on he TMA, three NAs and one unit two NAs and one nurse. The ated at that time the amount of equaled 3.99 to 4.00 hours (ppd). The administrator at time the staff were "saying and it was not making sense." Indicated the decision was not the DON to split the 300 unit for six residents on the 200 ator indicated he did not feel "prioritizing" their time when not having had enough staff to the lack of prioritization of the staff were complaining and the staff were complained to the was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO) to the administrator stated he was aff executive Officer (CEO	F8	35			

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F 835	would receive calls why we were over i administrator indicator front" the ppd was working with the coadministrator indicator staff based on acui current acuity of 0.5 increase staff. The able to go back to the NA with a census of had not gone back staff based on staff concerns with long part of the issue was capture acuity to sure doing for each resident of the indicator in the administrator in which was confirment that day, the NAs whot 1:11 as indicated the facility were expected lights when need he was aware of cocouncil regarding lowent onto the unit the work of staff residents willights to be answere the did not think it were met and further residents about the administrator indicator staff residents willights to be answere the did not think it were met and further residents about the administrator indicator staff residents willights to be answere the did not think it were met and further residents about the administrator indicator staff residents willights to be answere the did not think it were met and further residents about the administrator indicator staff residents willights to be answere the did not think it were met and further residents about the administrator indicator staff residents willights to be answere the did not think it were met and further residents about the administrator indicator staff residents willights to be answere the did not think it were met and further residents.	from corporate questioning in staffing hours. The lated "we try to have a united "out of our hands we are imporate" office. The lated at one point he increased try, however indicated their of did not reflect a need to administrator indicated he was the CEO and ask for another of 65, however confirmed he to the CEO to ask for more and resident expressed wait times. The DON stated as "lack of system" to chart and apport what the staff were dent. The DON indicated they with the staff, however the staff the accuracy of the charting in ereflected in case mix in would impact staffing hours. Indicated with a census of 51, and as the current census for were staffed at a 1:12.75 and and in the facility assessment. Indicated department heads at late to a did in the facility assessment. Indicated department heads at late to see if the resident's needs are indicated "some" of the swere related to staff talking to in one concerns. The lated regardless of the amount lated. The administrator indicated was a lack of staffing, however the staff "don't want to work to staff "don't want to work to a staff "don't want	F	835			

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F 835	Continued From pa	age 136	F 83	5		
F 838 SS=F			F 83	8		12/29/19
	facility-wide assess resources are necest competently during and emergencies. Update that assess least annually. The update this assess facility plans for, an substantial modificates assessment. The factories or include: §483.70(e)(1) The including, but not lift (i) Both the number resident capacity; (ii) The care required considering the type physical and cognition and other pertinent that population; (iii) The staff comperovide the level are resident population; (iv) The physical ereservices, and other that are necessary (v) Any ethnic, cultimay potentially affer	enduct and document a sment to determine what essary to care for its residents to both day-to-day operations. The facility must review and ement, as necessary, and at facility must also review and ment whenever there is, or the many change that would require a mation to any part of this facility assessment must easily assessment must easily assessment population, and the facility's resident population es of diseases, conditions, the disabilities, overall acuity, a facts that are present within etencies that are necessary to and types of care needed for the estimate of the population; and the care for this population; and the care provided by the ut not limited to, activities and				

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F 838	§483.70(e)(2) The but not limited to, (i) All buildings an and vehicles; (ii) Equipment (me (iii) Services provi pharmacy, and sp (iv) All personnel, employees and th contract), and volueducation and/or trelated to resident (v) Contracts, meror other agreement services or equipment of the agreement services or equipment and operations (vi) Health information with or §483.70(e)(3) A facommunity-based all-hazards approarmis REQUIREMED by: Based on intervier facility assessment or practices necessineeds regarding so which had the pote (R9, R25, R14, R2). In addition, the facaccurately reflect.	e facility's resources, including d/or other physical structures edical and non- medical); ded, such as physical therapy, ecific rehabilitation therapies; including managers, staff (both ose who provide services under unteers, as well as their raining and any competencies care; morandums of understanding, nts with third parties to provide nent to the facility during both and emergencies; and ation technology resources, for electronically managing delectronically sharing ther organizations.	F8	338	1.The facility assessment has beer reviewed and updated on 12/17/20 facility assessment will be reviewed QA committee on 12/19/2019 to en accuracy 2.This has the potential to affect all residents in the facility 3.Department heads have been in serviced on the facility assessment 12/17/2019 to ensure it accurately represent the needs of our residents and who provide care. 4. The administrator or designee will	on reflects		

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F 838	The Facility Assess lacked evidence of abuse and specific alcohol and/or substitute alcohol and/or substitute (d/x) dated 11/12/1 R9 had a d/x of alcadmission; R25 had a d/x of aladmission; R18 had a d/x of aladmission; R18 had a d/x of aladmission; R43 had a d/x of aladmission; R43 had a d/x of aladmission; R27 had a d/x of aladmission; R27 had a d/x of aladmission. Nursing assistant (11/5/19, at 2:32 p.r enough staff to me NA-B indicated the needed to be trans which required two with behaviors who	sment reviewed 9/19/19, alcohol and/or substance care or practices related to stance abuse. d a list with resident diagnoses 9, which included: ohol dependence since cohol use since admission; coholic cirrhosis since cohol abuse since admission; cohol dependence since pioid abuse since admission; pioid dependence since cohol abuse since admission; pioid dependence since cohol abuse since admission; cohol dependence since NA)-B was interviewed on m. and stated they did not have et the resident's care needs. re were too many resident who ferred with mechanical lifts NAs and too many resident or required attention and which nat would not get done due to	F 836	,	eted weekly x Its will be		
	and stated there we when there was a common two NAs for 30 plus NA-C indicated due staff would do the learning the staff would do the learning the staff would do the learning the staff would be staff w	ved on 11/6/19, at 8:41 a.m. as not enough staff especially call in and there would only be s residents on the 200 unit. The to resident care needs the pest they could just to optial cares for the day.					

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F 838	interviewed on 11/6 on average the stale instead of three two had been long call staff and indicated resided on the 200 and assistance who and resulted in rescompleted. The Facility Assess indicated the assess what resources we residents compete operations and emscheduled to ensure meet the needs of and further indicate based on census a appropriate support assessment indicate to have had a 1:11 1:14 ratio during on The assessment for overnight there was nurses. Furthermo assistance with acconjunction to the included transfer a resident range 1-20 residents 1-20 and	nurse (LPN)-C was 6/19, at 2:21 p.m. and stated ff would only have two NA's ice weekly. LPN-C stated there lights as a result of not enough some of the residents whom unit required more patience ich required more staff time ident cares not having been sement reviewed 9/19/19, sement was used to determine re necessary to care for the ntly during both day to day ergencies. Staff were re sufficient staff were able to the residents at any given time and staff patterns were adjusted and acuity levels while providing it for the residents. The sted direct care staff- NA were ratio on days/ evenings and vernights in long term care. In the assessment identified in its to have been 1:50 ratio for re, the assessment identified sivities of daily living in dentified staffing ratios sesistance for an independent 6, one to two staff range of dependent resident range at health needs resident range	F 83	38		
	11/8/19, at 9:01 a.r	or (SD) was interviewed on m. and stated the facility would a 100 unit, three NAs on the				

` '		` IDENTIFICATION NUMBED: ` `		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 838	200 unit and one in nurse per unit on overnight shift the one nurse for the 200 and 300 unit. The following staffi were reviewed from and revealed the form 10/4/19, the stwo NAs on the 200 would have been -On 10/10/19, the a.m. until 6:00 a.m. the 200 and 300 unurse, SD verified 1:33 to 40; -On 10/18/19, the shift was "short" overified the NA rat -On 10/20/19, the overnight shift the facility. The posted SD verified census indicated the nurse -On 11/2/19, the sovernight shift the NAs in the facility. reviewed and SD variable in the facility. The posted SD verified census indicated the nurse -On 11/2/19, the sovernight shift the NAs in the facility. reviewed and SD variable in the facility. The administrator were interviewed of administrator verifinot accurate having the strength of the s	NA on the 300 unit plus one days/ evenings. SD stated on re would be one NA per unit, 100 unit and one nurse for the During the interview SD verified ng schedules and posted hours in 10/1/19, through 11/12/19, collowing: chedule indicated there were 100 unit, SD verified the NA ratio 11:15 to 16; schedule indicated from 4:00 in the 200 unit NA covered both in it with assistance from the the NA ratio would have been schedule indicated the evening in e NA on the 200 unit, SD io would have been 1:15 to 16; schedule indicated during the re was only one nurse for the distaff hours were reviewed and is was 57 on 10/20/19, which	F&	338			

(X3) DATE SURVEY COMPLETED	
; 2/2019	
2.2010	
(X5) COMPLETION DATE	
12/29/19	
1	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245304	B. WING		1.	C 1/12/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ACTION SHOULD BE COMPLETE DATE		
F 867	presently trying to a QAPI action plar reviews up to date not aware of any colong for call lights; when a resident are aware of a long can administrator state completed to deter residents' request stated he had not minutes concerns and stated the depresponsible for folloconcerns from resistated the resident light wait time and to QAPI and had made no actic Administrator state residents and famic completed since the corporate had stop During interview with 1/12/19, at 4:32 pix QAPI meetings and stated there is a long to staff response discussion had bewait time and staff probably staffing in could be improved of any call light way MD stated he had narcotics diversion had been address.	inistrator stated they were recruit new employees and had a to get staff performance. Administrator stated he was omplaints of residents waiting to be answered until yesterday and family member made him Il light wait for staff assistance. Administrator assistance. Administrator assistance. Administrator assistance. Administrator and the resident council of long call lights and staffing partment heads were ow up with the monthly ident council. Administrator accouncil concerns of long call staffing had not been brought not been discussed and QAPI on plan for long call lights. Administrator accouncil concerns of long call staffing had not been brought not been discussed and QAPI on plan for long call lights. Administrator accouncil concerns of long call lights and satisfaction surveys with a staffing he beginning of the year when	F 8	monthly for 6 months. Resureviewed by the governing befurther recommendations.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245304	B. WING _		11	C / 12/2019	
	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009	•	11/12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
made and bein Dur (DC R32 (mill exp not she she how the not file. recce exp eve had med or diversity their com Dur (CP stat for the stat for the stat stat for the stat stat stat stat stat stat stat sta	was not aware ag done. ing interview won) on 11/12/19 Is two bottles of lained licensed count those two started her shi suspected the vever, was unsured. B.00 ml of morphave any medi. DON stated should be caused to the count that all ry shift change no other monification storage ocumentation of ersion. ing interview work and the county in the county work and the county of the	ith the director of nursing at 12:22 p.m. DON verified of morphine sulfate with 1.00 ml may be morphine. DON practical nurse (LPN)-D did to bottles per their policy when fit that morning. DON states 1 ml may be morphine. DON verified R32 did cation disposition records on the did not audit the narcotic sand stated it was her all narcotics were reconciled at with two staff. DON stated she toring being completed for eladministration or monitoring on the units for narcotic with the administrator on p.m. administrator confirmed that audits of narcotic use documentation. The consultant pharmacist on 11/12/19, at 2:57 p.m. CP and of pharmacy it was expected at the facility to destroy	F 86	57			
not file. record exp eve had med or diversity there com	have any medinoon stated should be caused by shift change no other monification storage ocumentation of the caused by shift change no other monification storage ocumentation of the caused by shift changes and should be should	cation disposition records on the did not audit the narcotic is and stated it was her all narcotics were reconciled at with two staff. DON stated she toring being completed for eladministration or monitoring on the units for narcotic with the administrator on p.m. administrator confirmed hal audits of narcotic use documentation. With the consultant pharmacist on 11/12/19, at 2:57 p.m. CP and of pharmacy it was expected at the facility to destroy and a "paper trail" should have					
en kept view of eting Aq	for a min the Sept genda m	tember 19, 2019, QAA/QAPI inductes indicated the					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245304	B. WING	B. WING			C 11/12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE	
F 867	how many residents choices for bathing indicated some bath moved to the night what date. Review minutes did not rev of resident call light assistance or suffice September minutes of discussion of narof medication storal. Review of the Octo Meeting Agenda mi "Measure" what % competency, training completed timely not indicated nursing were incompleted to date. The October QAPI were not matching "to get the lists upd was responsible for Review of the October veeal evidence of a light waiting time for staffing. Furthermonot reveal any evidediversion or monitor storage/administrat. During interview with p.m. DON stated in audits to determine	entified under "Measure" of swere not receiving their. The Action plan for follow up his and showers would be shift but did not indicate by of the September QAPI eal evidence of any discussion waiting time for staff ient staffing. Furthermore, the did not reveal any evidence recotics diversion or monitoring ge/administration. Der 17, 2019, QAA/QAPI inutes indicated under of staff did not have annual and pand performance review but identified. Action plan ould get the staff performance out did not say by what date. In minutes indicated bathing lists with NAs charting with Action ated" with no one noted who follow up and by what date. Der QAPI minutes did not any discussion of resident call or staff assistance or sufficient ore, the October minutes did ence of discussion of narcotics ring of medication ion. The DON on 11/8/19, at 1:02 arsing had completed no staff response time for long or resident requests for staff	F 8	67				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION NG	COMPLETED		
		245304	B. WING _			C / 12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 867			F 86	37		
F 880 SS=D	6/5/18, indicated the guidance for overal program and would promoted excellent resident choice, per and resident transitious areas would affected resident at care and services paffected the quality facility. The QAPI purpovement Projectake a systematic at care or services in attention. The QAPI annually by the QAPI annuall	Control stablish and maintain an and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable tions. In prevention and control stablish an infection prevention m (IPCP) that must include, at	F 88	30		12/29/19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245304	B. WING				_ 12/2019
	PROVIDER OR SUPPLIER	FALLS		300 I	EET ADDRESS, CITY, STATE, ZIP CODE NORTH DOW STREET INON FALLS, MN 55009		12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	§483.80(a)(1) A sysidentifying, reporting infections and commersidents, staff, voluindividuals providing arrangement based conducted according accepted national states with the system of survivial procedures for the but are not limited to (i) A system of survivial procedures for the persons in the facilia (ii) When and to whome communicable diserported; (iii) Standard and the to be followed to provide (iii) When and how it resident; including the facilia (ii) When and how it resident; including the facilia (iii) The type and do depending upon the involved, and (b) A requirement the least restrictive postic circumstances. (v) The circumstances (v) The circumstance contact with resider contact will transmit (vi) The hand hygier	stem for preventing, g, investigating, and controlling municable diseases for all unteers, visitors, and other g services under a contractual upon the facility assessment g to §483.70(e) and following tandards; en standards, policies, and program, which must include, oc: eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a put not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct ints or their food, if direct	F8	80			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	СОМ	E SURVEY IPLETED
		245304	B. WING		1	12/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG			(X5) COMPLETION DATE
F 880	§483.80(a)(4) A sy identified under the corrective actions to \$483.80(e) Linens. Personnel must hat transport linens so infection. §483.80(f) Annual The facility will con IPCP and update to IThis REQUIREME by: Based on observative review, the facility of catheter bag and infection control staresident (R20). In a ensure proper hand R20 during observationate (a cathete the bladder to drain Findings Include: R20 was observed his urinary catheter (a cathete the bladder to drain Findings Include: R20 was observed his urinary catheter floor. The urine drain hooked under the was propelled himself at the television area, spout was out of the clamped and observed a.m. the drainage is	stem for recording incidents a facility's IPCP and the aken by the facility. Indle, store, process, and as to prevent the spread of the program, as necessary. The spread of the program, as necessary. The spread of the provide safe handling at tubing in accordance with andards of practice for 1 of 1 addition, the facility failed to dwashing and glove usage for ation of care for a suprapubic ar placed below the navel into a urine). In 11/5/19, at 8:09 a.m. and a tubing was dragging on the placed back and forth. The emptying e holder although it was reved dragging on the floor. In again on 11/06/19, at 10:36 as ag was covered with a privacy and the tubing were	F8	1.The facility□s policy to maintainfection prevention program for to nursing cares provided to res Nursing staff competencies inclucatheter care and dressing charverified upon hire, annually and needed by the Clinical Nurse Edand/or designee. R20 has been a catheter bag holder to keep batubing off the floor. 2.This has the potential to affect resident with catheters 3.Nursing staff will be re-educatinfection control practices relate catheter care and the use of priviby 12/29/2019. The education wareview of infection control starexpected when providing reside minimize infections. 4.The infection preventionist or will audit for compliance. Audits completed daily x 4 weeks, wee monthly x 1. Results will be reviour Quality committee for further recommendation.	all related dents. Juding ages are as ucator provided ag and all facility ed on do acy bags ill include dards at care to designee will be kly x 4, ewed by	

, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING			C 11/12/2019	
	PROVIDER OR SUPPLIER	FALLS		300	REET ADDRESS, CITY, STATE, ZIP CODE NORTH DOW STREET NNON FALLS, MN 55009	1 11/	12/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	assessment dated diagnoses that includementia; had an ir required extensive mobility and transfer R20's admission re R20 had diagnoses history of malignant Review of care planthad suprapubic cathete saline, pat dry, apptimes a day for cathete salitizer. LPN-E the dressing on the suptook off the old dressing on the suptook off the old dressing. LPN-I performing hand hy and cleansed the cathete salik. Nurse Manager, Research	on Minimum Data Set (MDS) 8/14/19, indicated R20 had uded Alzheimer's disease and ndwelling catheter and assistance with toilet use, bed ers. accord dated 8/7/19 indicated of retention of urine and the neoplasm of the prostate. In dated 8/13/19, revealed R20 heter. Physician order dated 20 had permanent r, cleanse site with normal ly split gauze to secure two	F 8	80			
	stated R20 was on	hospice and orders were to ic site care twice a day. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245304	B. WING		11	C / 12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COE 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE	
F 880	be dragging on the bag should be kept verified the ProCar for incontinent care. LPN-E was intervied LPN-E stated the cosite care was to cleapply gauze. LPN-I use normal saline awet wipes during survey was intervented to the control Nurse. RN-B verified Control Nurse. RN-Staff changed glower cleaning up after a providing care for the change. RN-B expleducation was usu however, agency phave infection control of the facility did not he staff on infection control Guidelines indicates Standard care of all residents to blood, body fluid Employees must we seconds using antil soap and water undefore and after control enter the staff on after control gardents.	the catheter tubing should not floor and the urine drainage in a privacy bag. RN-A also be wet wipes were to be used be only. Ewed on 11/8/19, at 10:17 a.m. turrent order for suprapubic an with normal saline and E also verified that he did not and instead used the ProCare uprapubic site care. Of Nursing, Registered Nurse viewed on 11/08/19, at 12:04 she was also the Infection B stated it was the expectation as and washed hands after bowel movement and before the suprapubic dressing alined Infection control ally done with facility staff, ool staff were assumed to rol competencies prior to be facility. RN-B further stated have a system for training pool portrol. facility policy entitled Infection for all Nursing Procedures, Precautions will be used in the state of the suprapubic dressing and excretions and excretions apply so secretions and excretions apply so secretions and excretions are shands for 10 to 15 microbial or non-antimicrobial der the following conditions: ontact with blood, body fluids, so membranes or non-intact	F8	380			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245304	B. WING	···		C / 12/2019
NAME OF F	PROVIDER OR SUPPLIER	2.000		STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	12/2019
THE GAF	RDENS AT CANNON	FALLS		300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880	contaminated with blood, body fluids or secretions; after removing gloves.		F 8			12/29/19
SS=E	§483.95(g) Require aides. In-service training reservice training reservice service training reservice training reservice training reservice training compete be no less than 12 §483.95(g)(2) Inclustraining and resider §483.95(g)(3) Addresserving the special determined by the few services and services the special determined by the few services reservices and services the special determined by the few services reservices and services reservices and services reservices res	ed in-service training for nurse must- ufficient to ensure the ence of nurse aides, but must hours per year. de dementia management at abuse prevention training. ess areas of weakness as a aides' performance reviews ment at § 483.70(e) and may I needs of residents as facility staff.				
	address the care of This REQUIREMED by: In addition, the fact was provided for 4 E7) who were hired workers. This had the residents who reside	sonnel file revealed a hire date connel file revealed E4 was a		1.It is the facility policy to ensur staff have been trained abuse/vadult, dementia training and infecontrol at time of hire. 2.This has the potential to affect residents 3.All staff files have been reviewensure compliance with training abuse/vulnerable adult, dement and infection control. All staff incontract employees will be in se	rulnerable ection all facility red to for a training cluding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG	`´coм	E SURVEY PLETED	
		245304	B. WING			C 12/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLÉTIC HE APPROPRIATE DATE		
F 947	(AZ)/Dementia train revealed no evident training. Review of E5's per of 7/21/19. E5's per NA. E5's file reveal and AZ/Dementia to revealed no evident revealed no evident Review of E6's per of 11/29/18. E6's per NA. E6's file revealed no evident revealed no evident revealed no evident Review of E7's per of 10/4/19. E7's per licensed practical revidence of abuse/completed. E7's file training. During interview with (HR)/Staffing Direct a.m. HR/SD confirm AZ/Dementia, and and E7's personne had hired E4, E5, Eand were employed training had not be workers.	adult (VA) and Alzheimer's ning completed. E4's file ace of Infection Control (IC) sonnel file revealed a hire date resonnel file revealed E5 was a led no evidence of abuse/VA raining completed. E5's file ace of IC training. sonnel file revealed a hire date ersonnel file revealed E6 was ealed no evidence of abuse/VA raining completed. E6's file	F 9	abuse/vulnerable adult, der and infection control by 12/ 4. Human resources or des responsible to ensure compile will be completed monthly to be reviewed by our Quality further recommendation.	29/2019. ignee will be pliance. Audits x 3. Results will		

F5304030

PRINTED: 12/31/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION IG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245304	B. WING _		11/	04/2019
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	1OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	K 00	00		
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	POC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.				
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Division (The Gardens at Ca compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, annon Falls) was found not in a requirements for participation at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), Health Care.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY				
	Health Care Fire Instate Fire Marshal 445 Minnesota St., St Paul, MN 55101-	Division Suite 145		EPO	C	
	By email to: fm.hc.	Inspections@state.mn.us				
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	_	(X6) DATE

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.

Electronically Signed

12/29/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245304	B. WING			11/04/2019	
	PROVIDER OR SUPPLIER	FALLS		30	REET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUSE FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or proceed and to correct the defic 3. The name and/or responsible for corprevent a reoccurred. This facility will be Gardens at Cannot Center) is a 1-story. The building was content of the original building was determined to In 1982, addition working that working the Indiana working the Indiana working that working the Indiana working that working the Indiana working the India	RRECTION FOR EACH OT INCLUDE ALL OF THE DRMATION: what has been, or will be, done	K	0000			
	system. The facility full corridor smoke the corridors that is department notification. The facility has a corresus of 52 at the	apacity of 74 beds and had a time of the survey. t 42 CFR, Subpart 483.70(a) is					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245304	B. WING				11/04/2019	
	PROVIDER OR SUPPLIER	FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009				04/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
	with NFPA 96, Stan and Fire Protection Operations, unless: * residential cooking appliances such as toasters) are used cooking in accordar * cooking facilities occompartments with with the conditions or * cooking facilities in 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities proper 9.2.3 are not rechazardous areas, b corridor.	g equipment (i.e., small microwaves, hot plates, for food warming or limited nee with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, in smoke compartments with a comply with conditions under .4. Totected according to NFPA 96 equired to be enclosed as ut shall not be open to the	K3	324			12/29/19	
	by: Based on observat facility failed to prop when unattended by Life Safety Code NF 19.3.2.5.3). This de 52 residents. Findings Include:	ion and staff interview, the erly secure these stoves v staff in accordance with the FPA 101 - 2012 edition (eficient practice could affect een 08:00 AM and 01:00 PM			1. We contacted our electrician to it a timer/switch that would automatic shutoff the stove after a certain time 2. this will be completed when the equipment arrives. 3. The environmental service direct be responsible for correction and monitoring to prevent reoccurrence.	ally e limit.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245304	B. WING		11/	04/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		04/2010	
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
K 353	During walk-through Wing 100 Activities has stoves that did deactivate the units supervision. This deficient practification of the control o	ervations and staff interview	К3			12/29/19	
	Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspermaintained in a section available. a) Date sprinkler standard in a section of the sprinkler st	upply source KS information on coverage for partial automatic sprinkler		1.We contacted our sprinkler s monitoring company to come o			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245304	B, WING_		11/	04/2019
	ROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 712 SS=F	accordance with the 2012 edition (9.7.5 This deficient practice. This deficient practice. On facility tour betwon 11/07/2019, docinterview revealed to the During documentate provided to confirm system testing was this deficient practice. The Drills CFR(s): NFPA 101 Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the signal and simulating conditions. Fire drill unexpected times to least quarterly on ewith procedures and established routines between 9:00 PM and announcement may alarms. 19.7.1.4 through 19 This REQUIREMENT by: Based on document the facility failed to accordance with the	the sprinkler system in a Life Safety Code NFPA 101 - , 9.7.7, 9.7.8, and NFPA 25). Ice could affect 52 residents. Iveen 08:00 AM and 01:00 PM umentation review and staff the following: Ion review - no records were that quarterly sprinkler completed for Q2 - 2019 Ice was confirmed by the e Director at the time of The transmission of a fire alarm on of emergency fire is are held at expected and inder varying conditions, at each shift. The staff is familiared is aware that drills are part of the Where drills are conducted in the code of a wide code of the code o	K 35	inspect our sprinkler system 2. This was completed on 11/22/ 3. The environmental service dir be responsible for correction and monitoring to prevent reoccurrer	ector will dince.	12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		245304	B. WING_		11/04	/2019
	THE GARDENS AT CANNON FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 926	Findings Include: On facility tour betwon 11/07/2019, obstreviewed revealed During documentate provided to confirm Q1 2019 (3rd shift) This deficient practed Facility Maintenance discovery. Gas Equipment - QCFR(s): NFPA 101 Gas Equipment - QCPersonnel Personnel concerned maintenance and hocylinders are trained provide continuing guidelines and usas serviced only by permaintenance and on 11.5.2.1 (NFPA 99) This REQUIREMED by: Based on document the facility failed to training program in Safety Code NFPA	veen 08:00 AM and 01:00 PM ervation and documentation the following: ion review - no records were that fire drills were conducted:); Q2 2019 (2nd shift); Q4 ice was confirmed by the endirector at the time of equilifications and Training of ed with the application, andling of medical gases and don the risk. Facilities education, including safety ge requirements. Equipment is rsonnel trained in the apperation of equipment.	K 71	be responsible for correction as monitoring to prevent reoccurre	ng staff will 9 onitor for	2/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245304	B. WING	·	11/	04/2019	
	PROVIDER OR SUPPLIER	FALLS		STREET ADDRESS, CITY, STATE, ZIP CO 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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		SHOULD BE	(X5) COMPLETION DATE	
K 926	on 11/07/2019, obs reviewed revealed During documentat provided to confirm gas training is being by care staff. (prev F5304029)	veen 08:00 AM and 01:00 PM ervation and documentation	KS)26			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 6, 2019

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

Re: State Nursing Home Licensing Orders

Event ID: SW7U11

Dear Administrator:

The above facility was surveyed on November 4, 2019 through November 12, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

The Gardens At Cannon Falls December 6, 2019 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Eva Loch, Unit Supervisor Metro D Survey Team 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: eva.loch@state.mn.us

Phone: (651) 201-3792 Fax: (651) 215-9697

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Towards Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health The Gardens At Cannon Falls December 6, 2019 Page 3

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.11	o. oo.uo		A. BUILDING:			
		00758	B. WING		11/1	; 2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GARDENS AT CANNON FALLS			TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correspursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	p participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 12/17/19

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/1	2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON F	FALLS	TH DOW STR			
		CANNON	FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	Department of Heal you electronically. Is necessary for State enter the word "corn text. You must then State licensure proceompletion date, the corrected prior to el Minnesota Department" On 11/4/19 through Department's staff the following correct Please indicate in your correction that you and identify the date	Althorders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health. 11/12/19, surveyors of this visited the above provider and ation orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed.				
	H5304070C order is	ssued at St 0830 ssued at St 0830 ssued at St 0830 ssued at St 1525 ssued at St 0830 ssued at St 0830 ssued at St 0830 ssued at St 1995, and St 2000 ssued at St 0830				
2 130	MN Rule 4658.0050 duties) Subp. 1 Licensee;General	2 130			12/29/19
		I duties. The licensee of a sponsible for its management,				

Minnesota Department of Health

STATE FORM SW7U11 If continuation sheet 2 of 151

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ļ.		SURVEY LETED	
			A. BUILDING:				
		00758	B. WING		11/1	; 2/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GAI	RDENS AT CANNON I	FALIS	TH DOW STE				
			FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 130	Continued From pa	ge 2	2 130				
	control, and operati managed, controlle that enables it to us efficiently to attain of	on. A nursing home must be d, and operated in a manner se its resources effectively and or maintain the highest I, mental, and psychosocial					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure administration was managing facility resources to ensure resident needs were being met with respect to sufficient staffing ratios to promote the resident's highest practicable physical and mental function and well-being. This deficient practice had the potential to affect all 51 residents who resided at the facility.			Corrected			
	council group met t council function. Th and provided the fo -R24 stated "nothin had to wait a long ti answered, however follow-up with our c -R12 stated resider call lights to be ans -R18 stated she ha assistance and indi during meal times y "longer" for the call stated staffing had couple of months;	nts had to wait a long time for					

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING			C 12/2019
NAME OF	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY,	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	EALLS 300 N	NORTH DOW ST	REET		
THE GAI	NDENS AT CANNON I	CANI	NON FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 130	Continued From pa	nge 3	2 130			
	times he would not enough staff; -R15 stated there w light response and not always able to a regarding getting up		/ere			
	letters were reviewed 10/30/19, and reveating call lights and residents felt ig their call light without A letter dated 5/7/1/2 council lacked evidents.	eeting minutes and responed from 4/24/19, through aled the following: 4 4/29/19, indicated a concest were not answered timely gnored as staff were turning ut responding to their request, in response to the residence of call light and staff	ern g off est;			
	regarding call lights times and call lights without providing the The minutes dated not being answered average 45 minutes minutes indicated of turned off without a	d 5/29/19, indicated a conce is not answered during meal is were still being turned off he requested assistance; d 6/26/19, indicated call ligh d timely, residents reported is to one hour wait time. The call lights were still being hissisting the resident. The ficated they were being told	its on			
	there was not enou baths were not beir -The minutes dated were frustrated regifeeling as nothing viong call lights; -The minutes dated residents and five still no follow up on -The minutes dated expressed regarding	gh staff and showers and/	ts he d rns			

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STATEME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00758		B. WING		11/1	; 2/2019
NAME OF	PROVIDER OR SUPPLIER		1	STATE, ZIP CODE	1 11/1	2/2013
		300 NOR	TH DOW STR			
THE GAI	RDENS AT CANNON I	CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 130	Continued From pa	ge 4	2 130			
	regarding long call	ights wait times.				
	response letters lac	il meeting minutes and sked evidence of follow-up I concerns of long call light				
	11/6/19, at 1:37 p.n repeated staffing is residents complaine to meet their care n reached out to the complained to the complained to the complaints.	OMB) was interviewed on n. and stated there was sues. The OMB stated ed there was not enough staff eeds and indicated the OMB director of nursing (DON) a these concerns, however response.				
	at 2:18 p.m. and ve	vas interviewed on 11/12/19, rified each department head follow up on each identified ent council.				
		1/4/19, through 11/12/19, the oncern were identified:				
	document review, the accommodate residual	n observation, interview and ne facility failed to lent preference for bedtime for l6) reviewed for choices.				
	document review, the timely toileting assist (R44) and weekly s	n observation, interview and ne facility failed to provide stance for 1 of 5 residents hower assistance for 1 of 5 o needed assistance with ing (ADLs).				
	document review, the sufficient staff were	n observation, interview and ne facility failed to ensure available to meet resident idents (R44, R43, R46, R7)				

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Minnesota Department of Health						
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OI CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
	00758		B. WING		11/12/2019	
NAME OF	200/(DED 00 0) (DD) (ED		DDECC CITY	STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALIS	TH DOW STF			
		CANNON	FALLS, MN	55009		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
.,		,	.,.0	DEFICIENCY)		
2 130	Continued From no		2 130			
2 130	Continued From pa	ige 5	2 130			
		for activities of daily (ADLs)				
		ents (R24, R12, R18, R37,				
		sed concerns during resident				
		addition, the facility failed to				
		to reduce resident to resident				
		f 5 residents (R15, R33, R55,				
	R56, R57) in the mo	emory unit.				
	The Facility Assess	sment reviewed 9/19/19,				
		sment was used to determine				
		re necessary to care for the				
		ntly during both day to day				
		ergencies. Staff were				
	•	e sufficient staff were able to				
		the residents at any given time				
		ed staff patterns were adjusted				
		nd acuity levels while providing				
	appropriate support	t for the residents. The				
	assessment indicat	ted direct care staff- NA were				
	to have had a 1:11	ratio on days/ evenings and				
		rernights in long term care.				
		irther indicated during the				
		s to have been 1:50 ratio for				
		re, the assessment identified				
		ivities of daily living in				
		dentified staffing ratios				
		ssistance for an independent				
		6, one to two staff range of dependent resident range				
		al health needs resident range				
	1-20 and benavioral	a noditi noods rosident range				
	The staffing directo	or (SD) was interviewed on				
		n. and stated the facility would				
		e 100 unit, three NAs on the				
		A on the 300 unit plus one				
		ays/ evenings. SD stated on				
		e would be one NA per unit,				
	one nurse for the 10	00 unit and one nurse for the				
	200 and 300 unit. D	During the interview SD verified				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SUR' COMPLETE	
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	H DOW STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 130	were reviewed 10/1 revealed the following -On 10/4/19, the so two NAs on the 200 would have been 11 -On 10/10/19, the so a.m. until 6:00 a.m. the 200 and 300 un nurse, SD verified to 1:33 to 40; -On 10/18/19, the so shift was "short" on verified the NA ratio -On 10/20/19, the so overnight shift there facility. The posted SD verified census indicated the nurse -On 11/2/19, the so overnight shift there NAs in the facility. The reviewed and SD verified and SD verified the nurse overnight shift there NAs in the facility. The posted SD verified census indicated the nurse overnight shift there NAs in the facility. The post and SD verified and SD verified and SD verified and SD verified the stand she sked the nursing staff, hower administrator's responsible to 11/2/19; -On 11/8/19, the so day shift there were with a current census. 1:15 to 16. The DON was interput. The DON was interput. The DON was interput. The put. The p	g schedules and posted hours /19, through 11/12/19, and ng: hedule indicated there were unit, SD verified the NA ratio 15 to 16; chedule indicated from 4:00 the 200 unit NA covered both it with assistance from the he NA ratio would have been chedule indicated the evening e NA on the 200 unit, SD would have been 1:15 to 16; chedule indicated during the e was only one nurse for the staff hours were reviewed and was 57 on 10/20/19, which had a 1:57 ratio; hedule indicated during the e were two nurses and two he posted staff hours were erified census was 53 on hedule indicated during the e only two NA's on the 200 unit us of 31 which indicated a viewed on 11/8/19, at 1:02 ff had been cut back this year administrator to increase wer the DON indicated the conse was no. The DON rator wanted to take a new ach on the transition care unit, m absolutely not due to the esident considering the acuity re unit was high already and	2 130			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00758	B. WING	1¹		C 12/2019
	NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS CANNON					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 130	11/8/19, at 1:33 p.m the facility assessmindicated their NA radministrator verification was considered and indicated there were call in seen around 1:12.7 administrator explain on acuity and indication was 0.9 which was was below their goad. The administrator in staff based on acuity would need have been acui	and DON were interviewed on a. The administrator verified tent was not accurate having atio was a 1:11. The ed on most days and when the staffing ratio would have '5 or greater. The ined they also staffed based ated their current case mix used to determine acuity and all of greater than 1.0 for acuity. Indicated in order to increase the their case mix number seen greater than 1.0. The medical director (MD) on m. MD stated he attended the laws aware some residents are wait time with call lights to for assistance. MD stated in made regarding call lighting. MD stated, "It was not aware at time audits being completed." The administrator stated ago the facility was staffed on the TMA, three NAs and one nurse two NA's and one nurse. The ated at that time the amount of equaled 3.99 to 4.00 hours (ppd). The administrator	2 130			
	indicated during that they couldn't do it a The administrator in	(ppd). The administrator it time the staff were "saying nd it was not making sense." ndicated the decision was id the DON to split the 300 unit				

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Minneso	ta Department of He	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00758	B. WING		1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	CTDEET A	DDDESS CITY (STATE, ZIP CODE	<u> </u>	
NAIVIE OF F	-ROVIDER OR SUPPLIER					
THE GAR	RDENS AT CANNON I	FALLS	TH DOW STF N FALLS, MN			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORI ORE	SCIDENTII TIIVO INI ONWATION)	TAG	DEFICIENCY)	INAIL	57.1.2
0.400	0 " 15		0.100			
2 130	Continued From page 8		2 130			
	nurse to also care f	or six residents on the 200				
	unit. The administra	ator indicated he did not feel				
	as if the staff were	"prioritizing" their time when				
		not having had enough staff				
		o the lack of prioritization of				
		h for me to go to my superior				
		vas over budget for the last				
		administrator indicated in				
		made "adjustments" and				
		one TMA on the 200 unit and unit. The administrator stated				
		e staff were complaining" and				
		affing decrease. The				
		ined in 9/2019, he received				
		is "superiors" at corporate to				
		ng to a 3.2 ppd for direct care				
		administrator indicated he was				
		ef Executive Officer (CEO) to				
		he administrator stated he				
	would receive calls	from corporate questioning				
		n staffing hours. The				
		ated "we try to have a united				
		out of our hands we are				
	working with the co					
		ated at one point he increased				
		ty, however indicated their				
		did not reflect a need to				
		administrator indicated he was he CEO and ask for another	>			
		of 65, however confirmed he				
		to the CEO to ask for more				
		and resident expressed				
		wait times. The DON stated				
		as "lack of system" to chart an	4			
		ipport what the staff were	_			
		dent. The DON indicated they				
		vith the staff, however the staf	F			

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did not understand the accuracy of the charting which would then be reflected in case mix numbers and in turn would impact staffing hours.

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			SURVEY PLETED
		00758	B. WING			C 12/2019
NAME OF F	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE	-	
THE GAR	RDENS AT CANNON I	FALLS	ORTH DOW STI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 130	which was confirmed that day, the NAs we not 1:11 as indicated. The administrator in the facility were expected lights when need he was aware of concouncil regarding lowent onto the unit to twe met and further resident's concerns residents about the administrator indicated of staff residents we lights to be answere he did not think it windicated he believe their ability." SUGGESTED MET The administrator, could develop and in procedures to ensure available to maintain physical, mental and each resident. The assurance committed audits to ensure contains the surface of the notation of	ndicated with a census of 5 ed as the current census for yere staffed at a 1:12.75 and of in the facility assessment indicated department heads pected to assist with answer eded. The administrator statement of the resident's needs of see if the resident's needs of the amount of the resident of the resident's needs of the amount of the resident of t	at ing ed he s g to nt ted er to ee e			
2 240	days. MN Rule 4658.0069 Disaster Planning	5 Subp. 3 Resident Safety a	and 2 240			12/29/19
	must have a writter	saster plan. A nursing hom disaster plan specific to th procedures for the protection	е			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C C C C C C C C C	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	AME OF PROVIDER OR SUPPLIER
THE GARDENS AT CANNON FALLS 300 NORTH DOW STREET CANNON FALLS, MN 55009	HE GARDENS AT CANNON
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (X5) COMPLETED TO THE APPROPRIATE DEFICIENCY)	PREFIX (EACH DEFICIENC
2 240 and evacuation of all persons in the case of fire or explosion or in the event of floods, tornadoes, or other emergencies. The plan must include information and procedures about the location of alarm signals and fire extinguishers, frequency of drills, assignments of specific tasks and responsibilities of the personnel on each shift, persons and local emergency departments to be notified, precautions and safety measures during tornado alerts, procedures for evacuation of all persons during fire of floods, planned evacuation routes from the various floor areas to safe areas within the building, or from the building when necessary, and arrangements for temporary emergency housing in the community in the event of total evacuation. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility assessment failed to identify specific care or practices necessary to meet identified care needs regarding substance and alcohol abuse, which had the potential to affect 9 of 50 residents (R9, R25, R14, R18, R12, R43, R32, R27, R54). In addition, the facility assessment failed to accurately reflect current staff ratios, which had the potential to affect all 51 residents who resided in the facility. Findings include: The Facility Assessment reviewed 9/19/19, lacked evidence of alcohol and/or substance abuse and specific care or practices related to alcohol and/or substance abuse. The facility provided a list with resident diagnoses (dk) dated 11/12/19, which included:	and evacuation of or explosion or in to or other emergency information and progression and drills, assignments responsibilities of the persons and local notified, precaution tornado alerts, propersons during fire routes from the valuation within the building, necessary, and arremergency housing of total evacuation. This MN Requiremely: Based on interview facility assessment or practices neces needs regarding such which had the pote (R9, R25, R14, R1 In addition, the facility. Findings include: The Facility Assess lacked evidence of abuse and specific alcohol and/or sub.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				·		С	
		00758	B. WING		11/	12/2019	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
THE GA	RDENS AT CANNON	FALLS	TH DOW STF FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
2 240	R9 had a d/x of alcadmission; R25 had a d/x of alcadmission; R14 had a d/x of alcadmission; R18 had a d/x of alcadmission; R43 had a d/x of operation of alcadmission; R27 had a d/x of alcadmission; R27 had a d/x of alcadmission. Nursing assistant (Incomplete the electron of the high acuity on the high acuity on the high acuity on the high acuity on the complete the esser of the electron of the high acuity on the complete the esser of the high acuity on the complete the esser of the high acuity on the complete the esser of the high acuity on the complete the esser of the high acuity on the complete the esser of the high acuity on the complete the esser of the high acuity on the complete the esser of the high acuity on the complete the esser of the high acuity on the complete the esser of the high acuity on the complete the esser of the high acuity on the high acuity of the h	cohol dependence since cohol use since admission; coholic cirrhosis since cohol abuse since admission; cohol dependence since NA)-B was interviewed on n. and stated they did not have et the resident's care needs. The were too many resident who ferred with mechanical lifts NAs and too many resident required attention and which at would not get done due to he 200 unit. Wed on 11/6/19, at 8:41 a.m. as not enough staff especially call in and there would only be as residents on the 200 unit. The to resident care needs the control of the day. Inurse (LPN)-C was Si/19, at 2:21 p.m. and stated	2 240				
	interviewed on 11/6 on average the staf instead of three twi had been long call staff and indicated						

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						:
		00758	B. WING			2/2019
NAME OF I		OTDEET AD		OTATE ZID OODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GARDENS AT CANNON FALLS			TH DOW STE			
	I		FALLS, MN	55009		
(X4) ID	_	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 240	Continued From pa	ge 12	2 240			
2 240	-		2 240			
		ch required more staff time				
		dent cares not having been				
	completed.					
	The Facility Assess	ment reviewed 9/19/19,				
	•	sment was used to determine				
		re necessary to care for the				
		ntly during both day to day				
		ergencies. Staff were				
		e sufficient staff were able to				
	meet the needs of t	the residents at any given time				
	and further indicate	d staff patterns were adjusted				
		nd acuity levels while providing				
		t for the residents. The				
		ed direct care staff- NA were				
		ratio on days/ evenings and				
		ernights in long term care.				
		rther indicated during the				
		s to have been 1:50 ratio for e, the assessment identified				
		ivities of daily living in				
		dentified staffing ratios				
		ssistance for an independent				
		o, one to two staff range of				
	_	dependent resident range				
	1-20 and behaviora	l health needs resident range				
	1-20.					
		(05)				
		r (SD) was interviewed on				
		n. and stated the facility would				
		100 unit, three NAs on the A on the 300 unit plus one				
		ays/ evenings. SD stated on				
		e would be one NA per unit,				
		00 unit and one nurse for the				
		Ouring the interview SD verified				
		g schedules and posted hours				
		10/1/19, through 11/12/19,				
	and revealed the fo	llowing:				
		hedule indicated there were				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00758	B. WING		C 11/12/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GARDENS AT CANNON FALLS			H DOW STR			
		CANNON	FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
2 240	Continued From page 13		2 240			
	two NAs on the 200 would have been 1: -On 10/10/19, the sa.m. until 6:00 a.m. the 200 and 300 un nurse, SD verified to 1:33 to 40; -On 10/18/19, the sa shift was "short" on verified the NA ratio -On 10/20/19, the sovernight shift there facility. The posted SD verified census indicated the nurse -On 11/2/19, the sovernight shift there NAs in the facility. The reviewed and SD verified census indicated the nurse -On 11/2/19; -On 11/8/19, the sovernight shift there was in the facility. The administrator accurrent census 1:15 to 16. The administrator awere interviewed or administrator verified not accurate having 1:11. The administrator explain acuity and indicated 0.9 which was below for acuity. The administrator explain acuity and indicated 0.9 which was below for acuity. The administrease staff based	unit, SD verified the NA ratio 15 to 16; chedule indicated from 4:00 the 200 unit NA covered both it with assistance from the ne NA ratio would have been chedule indicated the evening e NA on the 200 unit, SD would have been 1:15 to 16; chedule indicated during the was only one nurse for the staff hours were reviewed and was 57 on 10/20/19, which				

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The facility assessment policy was requested, but

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			COMPLETED	
		00758	B. WING		11/1	2/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GAR	RDENS AT CANNON F	ΣΔIIS	TH DOW STE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRESPONDER (CROSS)	D BE	(X5) COMPLETE DATE	
2 240	The administrator of policies/procedures components, educate ensure compliance. TIME PERIOD FOR (21) days.	HOD OF CORRECTION: ould review/revise for the facility assessment ate staff and perform audits to	2 240				
2 255	Assurance Commit A nursing home mu assessment and as of the administrator services, the medic designated by the n three other membe representing discipl resident care. The assurance committe respect to which qu necessary and deve appropriate plans o quality deficiencies address, at a minim reporting, infection pharmacy services. This MN Requirement	est maintain a quality surance committee consisting , the director of nursing al director or other physician nedical director, and at least rs of the nursing home's staff, ines directly involved in quality assessment and ee must identify issues with ality assurance activities are elop and implement f action to correct identified The committee must jum, incident and accident control, and medications and	2 255			12/29/19	
	by: Based on observati review, the facility fa (Quality Assurance committee identified breaks in systems a	on, interview and document ailed to ensure the QAPI Performance Improvement) di quality deficiencies with and incorporated action plans resident care and services.		Corrected			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			A. Boilding.			c	
		00758	B. WING			11/12/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GAI	RDENS AT CANNON	FALLS	TH DOW STF FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 255	F755 E, F835 F, F8 potential to affect a visitors in the facility. Findings include: During interview with at 2:18 p.m. the Adhad needed to utilizy workers. The admin presently trying to ra QAPI action plan reviews up to date. not aware of any colong for call lights to when a resident an aware of a long call Administrator stated completed to determinate to determinate concerns from residents' request from the stated the departs and stated the departs and stated the departs and stated the resident light wait time and sto QAPI and had no had made no action Administrator stated residents and familicompleted since the corporate had stop During interview with 11/12/19, at 4:32 p.	E, F689 E, F725 F, F730 E, 338 F, F947 E) This had the II 51 residents and their y. th administrator on 11/12/19, ministrator stated the facility the agency staff and contract histrator stated they were ecruit new employees and had to get staff performance. Administrator stated he was emplaints of residents waiting to be answered until yesterday of family member made him I light wait for staff assistance. In do call light audits had been mine staff response time to or assistance. Administrator ead the resident council of long call lights and staffing fartment heads were ow up with the monthly dent council. Administrator council concerns of long call staffing had not been brought to been discussed and QAPI in plan for long call lights. It is satisfaction surveys with the seed the process. The medical director (MD) on m. MD stated he attended the	2 255				
	11/12/19, at 4:32 p. QAPI meetings and stated there is a lor						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON F	FALLS	H DOW STR			
	Г	CANNON	FALLS, MN			
(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 SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 255	Continued From page 16		2 255			
	discussion had bee wait time and staffir probably staffing no could be improved. of any call light wait MD stated he had be narcotics diversion had been addresse the staff dismissed. made aware of the and was not aware being done.	n made regarding call light ng. MD stated, "It was at quite meeting the ratio and "MD stated he was not aware time audits being completed. been made aware of the in June and stated the issue d with the particular staff and MD stated he had not been September narcotics diversion of any audits or monitoring				
	(DON) on 11/12/19. R32's two bottles of (milliliters) and 8.00 explained licensed not count those two she started her shift she suspected the however, was unsuthe 8.00 ml of morp not have any medic file. DON stated she reconciliation books expectation that all every shift change whad no other monitomedication storage, or documentation of diversion. During interview with 11/12/19, at 12:40 pthere were no format completed and/or diversion.	at 12:22 p.m. DON verified for morphine sulfate with 1.00 ml ml were "missing." DON practical nurse (LPN)-D did bottles per their policy when that morning. DON states 1 ml was "thrown away," re about what happened with hine. DON verified R32 didication disposition records on e did not audit the narcotic and stated it was her narcotics were reconciled at with two staff. DON stated she oring being completed for administration or monitoring in the units for narcotic. The the administrator on the did and the complete did and the complete did and the complete did and the units for narcotic the administrator confirmed all audits of narcotic use ocumentation.				
		h the consultant pharmacist on 11/12/19, at 2:57 p.m. CP				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.110 1 27.11	or correction.	BERTH TOXITION HOMBER.	A. BUILDING:			
		00758	B. WING		11/1:	; 2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAR	THE GARDENS AT CANNON FALLS 300 NOF					
		TEMENT OF DEFICIENCIES	FALLS, MN			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 255	5 Continued From page 17		2 255			
	stated per the board of pharmacy it was expected for two individuals at the facility to destroy narcotics together and a "paper trail" should have been kept for a minimum of two years. Review of the September 19, 2019, QAA/QAPI					
	Review of the September 19, 2019, QAA/QAPI Meeting Agenda minutes indicated the percentage (%) of resident bathing with choice with the ratio not identified under "Measure" of how many residents were not receiving their choices for bathing. The Action plan for follow up indicated some baths and showers would be moved to the night shift but did not indicate by what date. Review of the September QAPI minutes did not reveal evidence of any discussion of resident call light waiting time for staff assistance or sufficient staffing. Furthermore, the September minutes did not reveal any evidence of discussion of narcotics diversion or monitoring of medication storage/administration.					
	Meeting Agenda mi "Measure" what % competency, training completed timely not indicated nursing we reviews up to date of the October QAPI were not matching "to get the lists upd was responsible for Review of the October eveal evidence of a light waiting time for staffing. Furthermore					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00758		B. WING		I	C 12/2019
THE GARDENS AT CANNON FALLS 300 NOR		300 NOR	DRESS, CITY, S TH DOW STF FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCII MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 255	During interview with p.m. DON stated not audits to determine call light wait time for assistance. The facility QAPI (Or Performance Improf 6/5/18, indicated the guidance for overal program and would promoted excellence resident choice, per and resident transit focus areas would in affected resident arear and services program and services program and services program and services in attention. The QAPI provement Projectake a systematic acare or services in attention. The QAPI provement was sindicated the QAPI annually by the QA	ch DON on 11/8/19, ursing had complete staff response time or resident requests Quality Assurance evement) Plan dated e QAPI plan provide I Quality Improvemed drive decision make in quality of care, rson centered directions. The QAPI plan include all systems the family satisfaction frovided, and all are of life for persons living lan indicated Perforcts (PIPS) were desproach to revise all areas identified that I plan indicated an indicated an indicated an indicated an indicated and indic	d no for long for staff Revision d ent ing that of life, ed care, indicated that n, quality of as that ving in the mance signed to nd improve needed mportant ed the the I plan also wed QAPI plan y. TION: DON or ing body to v issues, e the istrator esident tion of				
	restorative and rang report results to the		ms, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00758	B. WING		C 11/12/2019	
		00756			11/1	2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON F	ΣΔIIS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 255	Continued From page 19		2 255			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 285	MN Rule 4658.0100 Orientation and In-S		2 285			12/29/19
	must provide in-ser education must be seed continuing compete address areas identicassessment and as must address the seed determined by the reprogram in rehability to promote ambulate living; assist in activity of range of motion,	education. A nursing home vice education. The in-service sufficient to ensure the nce of employees, must tified by the quality ssurance committee, and pecial needs of residents as nursing home staff. A nursing an in-service training ation for all nursing personnel ion; aid in activities of daily vities, self-help, maintenance and proper chair and bed he prevention or reduction of				
	This MN Requirement is not met as evidenced by: In addition, the facility failed to ensure training was provided for 4 of 4 employees (E4, E5, E6, E7) who were hired by the facility as contract workers. This had the potential to affect all 50 residents who resided in the facility.			Corrected		
	Findings include:					
	of 8/7/19. E4's pers NA. E4's file revealed abuse/vulnerable ac (AZ)/Dementia train	connel file revealed a hire date onnel file revealed E4 was a led no evidence of dult (VA) and Alzheimer's ling completed. E4's file ce of Infection Control (IC)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00758	B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS 300 N	T ADDRESS, CITY, S ORTH DOW STR ON FALLS, MN	EET		
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2 285	training. Review of E5's pers of 7/21/19. E5's per NA. E5's file reveal and AZ/Dementia to revealed no eviden. Review of E6's pers of 11/29/18. E6's pers of 11/29/18. E6's pers of 10/4/19. E7's file training. During interview with (HR)/Staffing Direct a.m. HR/SD confirm AZ/Dementia, and and E7's personnel had hired E4, E5, Est and were employed training had not been workers. A policy was reques provided. SUGGESTED MET The director of nurs develop, review, an procedures regarding the state of	sonnel file revealed a hire described in the sonnel file revealed E5 was ed no evidence of abuse/V/raining completed. E5's file ce of IC training. sonnel file revealed a hire described in the sonnel file revealed E6 was aled no evidence of abuse/raining completed. E6's file	ate as VA late as VA late as a lang C la			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00758	B. WING		11/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON	EXIIC	TH DOW STE I FALLS, MN			
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2 285	Continued From pa	nge 21	2 285			
	DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee.					
	(21) days.	R CORRECTION: Twenty-one				
2 335	MN Rule 4658.0130 Employees' Personnel Records		2 335			12/29/19
	A current personnel record must be maintained for each employee and be stored in a confidential manner. The personnel records for at least the most recent three-year period must be maintained by the nursing home. The records must be available to representatives of the department and must contain:					
	A. the person's name, address, telephone number, gender, Minnesota license, certification, or registration number, if applicable, and similar identifying data; B. a list of the individual's training, experience, and previous employment; C. the date of employment, type of position currently held, hours of work, and attendance records; and D. the date of resignation or discharge.					
	record of all accide reportable under pa	information, including the nts and those illnesses art 4605.7040, must be red in a separate employee				
	by:	ent is not met as evidenced ion, interview and document		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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2 335	Continued From pa	ge 22	2 335				
	review, the facility failed to ensure performance evaluations were completed for 3 of 5 nursing assistants (E1, E2, E3) who had worked at the facility for over a year.						
	Findings include:						
	Review of E1's personnel file revealed a hire date of 10/27/14. E1's personnel file revealed E1 was a nursing assistant (NA) who had worked at the facility over a year. E1's file revealed no evidence of a performance evaluation (PE) completed. Review of E2's personnel file revealed a hire date of 3/23/18. E2's personnel file revealed E2 was a NA who had worked at the facility over a year. E2's file revealed no evidence of a PE completed. Review of E3's personnel file revealed a hire date						
	NA who had worke	rsonnel file revealed E3 was a d at the facility over a year. to evidence of a PE completed.					
	During interview with Human Resources (HR)/Staffing Director (SD) on 11/12/19, at 10:39 a.m. HR/SD confirmed there were no PEs in E1's, E2's, and E3's personnel files. HR/SD stated E1's, E2's, and E3's PE's were "overdue" and should be completed annually.						
	A policy was requested from the facility and not provided.						
	The director of nurs review policy for pe staff on those polici including nursing as performance has be	THOD OF CORRECTION: sing and/or designee could rformance reviews, educate es to ensure nursing staff, ssistance, to staffs' een reviewed. The DON or duct audits of employee files					

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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2 335	Continued From pa	ge 23	2 335			
	to ensure the emplo	oyee performance reviews				
		ed on a consistent basis.				
	•					
	TIME PERIOD FOR	R CORRECTION: Twenty-one				
	(21) days.					
2 800	MN Rule 4658.0510	Subp. 1 Nursing Personnel;	2 800			12/29/19
	Staffing requiremen	nts				
		requirements. A nursing				
		n duty at all times a sufficient				
		nursing personnel, including				
		icensed practical nurses, and				
		to meet the needs of the				
		ses' stations, on all floors, and one building is				
		ides relief duty, weekends,				
	and vacation replac					
	and vacation replac	ements.				
	This MN Requireme	ent is not met as evidenced				
	by:					
	Based on observati	on, interview and document		Corrected		
		ailed to ensure sufficient staff				
		eet resident needs for 4 of 5				
		3, R46, R7) dependent on staff				
		(ADLs) and for 5 of 9				
		2, R18, R37, R51) whom				
		s during resident council				
	•	n, the facility failed to provide				
		ce resident to resident 5 residents (R15, R33, R55,				
		emory unit. The lack of				
		affing had the potential to				
	affect all 51 residen					

	Findings include:					
	R44 was observed	on 11/8/19 at 7:40 a.m. with				

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NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE GARDENS AT CANNON F	ΔIIS	TH DOW STR FALLS, MN				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
had been on the bed minutes" and neede bed pan as he had " At 8:05 a.m. nursing observed to answer R44's room R44 sta "waiting more than I to have had a bowel pericares and assist R44 stated to NA-A minutes" and NA-A fast as the two of us R44's quarterly Minit 10/7/19, identified R diagnoses which inc depression. The MD extensive assist with incontinent of bowel R44 was interviewed stated staff when sta a long time for assis his call light. R44 sta occur almost daily a weekends. NA-A was interviewed and confirmed R44 minutes on the bedp "really far behind" ged due to only having to have had three NAs behind due to having the lad three NAs behind the lad thre	2:59 a.m. R44 indicated he d pan waiting for "30 to 45 and assistance to get off of the been done for a long time." assistant (NA)-A was R44's call light when entering ted to NA-A he had been should." R44 was observed I movement NA-A provided ted R44 off of the bed pan. he had been waiting "45 replied "we are working as can." The mum Data Set (MDS) dated the thad intact cognition and cluded dementia and manic DS indicated R44 required in toileting and was frequent without a toileting program. Indicated R44 required in toileting and was frequent without a toileting program. Indicated R45 a.m. and aff would call in he would wait stance from staff after alerting ated facility staff issues would and was worse on the least 30 oan. NA-A stated they were etting residents up for the day wo NAs when they should	2 800				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		00758		B. WING		l l	C 11/12/2019	
		00756				11/	12/2019	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GA	RDENS AT CANNON I	ΕΔΙΙς	300 NOR	TH DOW STR	REET			
IIIL OAI	ADENO AT CAMITOR I	ALLO	CANNON	FALLS, MN	55009			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 800	Continued From page 25			2 800				
	up out of bed.							
	The Staffing Director 11/8/19, at 9:01 a.n only two NA's work in the needed three N unable to find a nur to "pull" a NA to wo aide which left only The director of nurs	n. and confirmeing on the 200 the As. SD explaines to work so the traine two NAs.	d there were unit instead of ed she was he facility had medication					
	11/8/19, at 1:06 p.n staff to respond as	n. and stated sh	ne expected					
	R43's annual MDS dated 10/3/19, identified R43 had intact cognition and diagnoses which included anemia, end stage renal disease, peripheral vascular disease and diabetes mellitus. The annual MDS further indicated R43 required supervision and/or oversight with ADLs.							
	R43's Bathing Report was reviewed 9/15/19, through 11/7/19, and directed staff to shower R43 every Thursday at 8:00 p.m. male caregiver only and the documentation revealed the following: -On 9/15/19, the report indicated R43 refused bathing;							
	-On 9/22/19, the re Applicable;" -On 9/29/19, the re Applicable;" -On 10/13/19, the re	port indicated b	athing "Not					
	Applicable;" -On 10/27/19, the rewith bathing; -On 10/31/19, the reapplicable;" -On 11/7/19, after sindicated extensive	eport indicated curvey began, th	bathing "Not					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		I	C 12/2019
	PROVIDER OR SUPPLIER	FALLS 300 NOR	DDRESS, CITY, S TH DOW STR I FALLS, MN			
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2 800	Family member (FN telephone on 11/5/R43 had not had a FM-B stated a weel please" ensure R43 a male would show waited an hour and shower and stated staff and asked who FM-B stated the stard when she cathree days later R4FM-B stated she explast care conference completed and the into it. R43 was interviewed stated he "wants a have long 0.25 inchunderneath the nail on them, and R43 when he had requesto assist him.	M)-B was interviewed via 19, at 10:33 a.m. and stated shower in over two weeks. It ago she "asked the nurse B was showered and requested er R43. FM-B indicated she nobody came to offer R43 a she then approached a male en R43 would be showered. If indicated he was unaware wer and walked away. FM-B ame back to visit R43 two to 3 "still" had not had a shower. It is regarding showers not staff indicated they would look and on 11/6/19, at 8:32 a.m. and shower. R43 was observed to a finger nails with brown dirt, dirty clothing with food stains was malodorous. R43 stated hower in over two weeks and sted no staff would come back		DEFICIENCY)		
	and verified R43 ha weeks. NA-B stated resident's whom re- cares and/ or transi enough staff to con explained in additio two staff there were required two staff a constant behavior in meet the resident's	yed on 11/5/19, at 2:32 p.m. and not had a shower for three of there were too many quired two people to provide fers which would result in not applete showers. NA-B in to residents whom required a also too many lifts which and resident's whom required interventions for the staff to basic care needs. NA-B complained to the DON.				

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2 800	NA-C was interview and confirmed R43 while. NA-C explair miss" their schedul would be moved to day due to not enow was not time to look plans due to having most days there we residents and the sigust to complete includes care needs of basic care was price stated the staff had have enough staff to needs, however included the staff had have enough staff to needs, however includes the staff with two NAs vs. the showers would not for two NAs to complete includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs, however includes the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to needs on the staff had have enough staff to ne	nothing changed. yed on 11/6/19, at had not had a shower and the ded shower and the the next day and ugh staff. NA-C in a tage to only two NAs at the residents. Narity over showers notified the DON to meet the residents. Narity over showers notified the DON to meet the residents of the NAs and indicated no change the NAs and indicated no change the NAs and indicated as it was plete all of the base of the swering lights to be an always have the swering lights" the been here. ed on 11/8/19, at the per expectation for hower schedule was the expected a quest and confirm in the past two waterview was comm. and stated the	lower in a he residents e shower / or the next dicated there dent care NA-C stated for 30-32 hey could do nd/ or meet A-C stated . NA-C I they did not ent care es occurred. It is and stated he 200 unit cated as not realistic sic cares on would wait a swered and DON and ey did that 12:07 p.m. R43 to be which was male staff to led R43 had reeks. A pleted on e facility	2 800			

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a Natudo 22 con Trong FO con a series for the serie	and stated there we oileting and bathing done. NA-J indicate due to acuity and care timely. The facility policy recepted, but not provided the formulation of the council group met to council function. The and provided the formulation and to wait a long time answered, however collow-up with our call lights to be answered stated resident call lights to be answered and indicated staffing had expected by the call stated there we wight response and into always able to a regarding getting up the call always able to a regarding getting up the call stated there we get always able to a regarding getting up the call stated there we get always able to a regarding getting up the call stated there we get always able to a regarding getting up the call stated there we get always able to a regarding getting up the call stated there we get always able to a regarding getting up the call stated there we get always able to a regarding getting up the call stated there we get always able to a regarding getting up the call stated there we get the call the call stated there we get the call th	ers. ed on 11/12/19, at 9:25 a.m. ere not enough NAs and g/ showers would not get ed three NAs were not enough are needs. NA-J stated the ar NAs to complete resident egarding toileting was provided. p.m. members of the resident or review the facility resident or review the facility resident e following residents attended flowing information: g gets fixed" here we have me for call lights to get r nobody did anything to oncern; ats had to wait a long time for wered; d to wait a long time for staff cated if you were in your room you would have to wait even light to be answered. R18 gotten worse over the past me for staff assistance had he past few months and at get showers due to not erere long wait times for call indicated due to this staff were he accommodate his choice	2 800			

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CLIMMAD V CTA		FALLS, MN		ON	0.45
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2 800 Continued From page	ge 29	2 800			
and revealed the fol-The minutes dated regarding call lights and residents felt ig their call light without. A letter dated 5/7/1 council lacked evide concerns; -The minutes dated regarding call lights times and call lights without providing the The minutes dated not being answered average 45 minutes minutes indicated of turned off without as minutes further indicated were frustrated regarding as nothing was long call lights; -The minutes dated were frustrated regardeling as nothing was long call lights; -The minutes dated residents and five sestill no follow up on the minutes dated expressed regarding overnight shift and seregarding long call lights; -The ombudsman (Counter the complained there was not enough the minutes dated expressed regarding long call lights; -The minutes dated expressed regarding long call lights and seregarding long call lights are garding long call	llowing: 4/29/19, indicated a concern were not answered timely nored as staff were turning off at responding to their request; 9, in response to the resident ence of call light and staff 5/29/19, indicated a concern not answered during meal were still being turned off e requested assistance; 6/26/19, indicated call lights timely, residents reported on a to one hour wait time. The call lights were still being sisting the resident. The cated they were being told gh staff and showers and/ or g completed; 7/31/19, indicated residents arding no resolution and was being done regarding the 10/10/19, indicated 20 taff were in attendance and long call light wait times; 10/30/19, indicated concerns g not enough staff during the still waiting for a response	2 800			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALIS	TH DOW STE			
		CANNON	FALLS, MN	55009		
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2 800	Continued From pa	age 30	2 800			
	The Facility Assess	sment reviewed 9/19/19,				
		sment was used to determine				
	what resources wer	re necessary to care for the				
		ntly during both day to day				
	operations and eme	ergencies. Staff were				
	scheduled to ensur	e sufficient staff were able to				
	meet the needs of t	the residents at any given time				
	and further indicate	ed staff patterns were adjusted				
		nd acuity levels while providing				
		t for the residents. The				
		ted direct care staff- NA were				
		ratio on days/ evenings and				
		vernights in long term care.				
		orther indicated during the				
		s to have been 1:50 ratio for				
		re, the assessment identified				
		ivities of daily living in				
		dentified staffing ratios				
		ssistance for an independent				
		6, one to two staff range of				
		dependent resident range al health needs resident range				
	1-20 and benavioral	il fleatiff fleeds festdefit fange				
	1-20.					
	The staffing directo	or (SD) was interviewed on				
	O	n. and stated the facility would				
		e 100 unit, three NAs on the				
		A on the 300 unit plus one				
		ays/ evenings. SD stated on				
		e would be one NA per unit,				
		00 unit and one nurse for the				
		During the interview SD verified				
		g schedules and posted hours				
		I/19, through 11/12/19, and				
	revealed the followi					
	-On 10/4/19, the sc	chedule indicated there were				
	two NAs on the 200	unit, SD verified the NA ratio				
	would have been 1:					
		schedule indicated from 4:00				
	a.m. until 6:00 a.m.	the 200 unit NA covered both				

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		00758		B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS	300 NOR	DRESS, CITY, STH DOW STF			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC MUST BE PRECEDED B SC IDENTIFYING INFORM	IES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	the 200 and 300 unit with assistance from the nurse, SD verified the NA ratio would have been 1:33 to 40; -On 10/18/19, the schedule indicated the evening shift was "short" one NA on the 200 unit, SD verified the NA ratio would have been 1:15 to 16; -On 10/20/19, the schedule indicated during the overnight shift there was only one nurse for the facility. The posted staff hours were reviewed and SD verified census was 57 on 10/20/19, which indicated the nurse had a 1:57 ratio; -On 11/2/19, the schedule indicated during the overnight shift there were two nurses and two NAs in the facility. The posted staff hours were reviewed and SD verified census was 53 on 11/2/19; -On 11/8/19, the schedule indicated during the day shift there were only two NA's on the 200 unit with a current census of 31 which indicated a 1:15 to 16. The administrator and DON were interviewed on 11/8/19, at 1:33 p.m. The administrator verified the facility assessment was not accurate having indicated their NA ratio was a 1:11. The administrator verified on most days and when there were call in's the staffing ratio would have been around 1:12.75 or greater. The administrator explained they also staffed based on acuity and indicated their current case mix was 0.9 which was used to determine acuity and was below their goal of greater than 1.0 for acuity. The administrator indicated in order to increase staff based on acuity their case mix number would need have been greater than 1.0. The DON verified the facility currently had 12 resident's whom resided in the facility who were total dependent on staff for transfers with use of the full body lift. The DON indicated there were additional residents whom required two person		2 800				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAI	RDENS AT CANNON F		TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 800	was used, however number of residents During interview wit 11/12/19, at 4:32 p. QAPI meetings and stated there is a longet staff response f discussion had bee wait time and staffir probably staffing no could be improved. of any call light wait Call light audits wer Sufficient staffing portain staffing portain was paraplegia (paralysi Annual MDS R46's cognition was paraplegia (paralysi Annual MDS indicat Dependence two stand Extensive two stand Extensive two stoileting, grooming, under Section E- In was marked (-) for timportant to choose On 11/4/19, at 6:06 room two times with -At 6:17 p.m. direct hallway and told reg	iors and when the stand lift did not verify the actual s. h medical director (MD) on m. MD stated he attended the was aware some residents g wait time with call lights to or assistance. MD stated n made regarding call light ng. MD stated, "It was to quite meeting the ratio and 'MD stated he was not aware time audits being completed. e requested, but not provided. olicy request, but not provided.	2 800			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					l c	,
		00758	B. WING			, 2/2019
		00736			11/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		300 NORT	TH DOW STE	REET		
THE GAR	RDENS AT CANNON F	FALLS	FALLS, MN			
040.15	CLIMMA DV CTA				NI.	0.(5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
				DEFICIENCY)		
0.000	0 " 15	00	0.000			
2 800	Continued From pa	ge 33	2 800			
	entered R46's room	and exited and left call light				
	on.	r and exteed and left can light				
		propelled himself in his w/c out				
		nall with his call light on.				
		said to unidentified nursing				
		nose call light is on?" NA told				
		niting to go to bed but R10's				
		d she wanted staff assistance				
	<u> </u>	and spilled a coca cola all				
		so wanted assistance to go to				
		NA to go and hook up R46 to				
		vent and told R10 she would				
	be helped after R46					
		identified staff walked past				
		g a resident in a w/c without				
		needed. At 6:25 p.m. there				
		activated on in the 200				
		was seated in her office, and				
		B and licensed practical nurse ig to each other at nurse				
		A-G, "I will meet you in R46's				
	room."	A-G, I will meet you in R40 s				
		nidentified NAs entered R4's				
	room with the trans					
		entered R23's room and told				
		d to wait and staff would help				
		nere are people [residents]				
	ahead of you."	entered P46's room and				
		entered R46's room and s ready for bed. R46 stated the				
		room with the lift. R46 he was]
		get into bed and my program]
	Chicago PD is com]
		call light over his door went]
	off, DON in R46's re					
		exited R46's room and stated]
		ee how much longer it would]
	take to get him assi]
		vas observed sitting in his w/c				
	at nurse station yell	ing, "Help! Help!"				

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00758	B. WING			2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STR			
0(4) ID	CLIMMA DV CTA		FALLS, MN		ON.	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 34	2 800			
	-At 6:30 p.m. DON number which had exited room with ca -At 6:31 p.m. R46 chis room waiting for light onAt 6:33 p.m. no ca -At 6:33 p.m. R46 croom to go to bedAt 6:38 p.m. R10 a over their room doc -At 6:40 p.m. R46 vroom into hallway lot lot R46 she could while he was waitin -At 6:44 p.m. R46 vin his room with RN transfer liftAt 6:47 p.m. NA ward RN-A to transfer R4 minutes for staff as -At 7:18 p.m. R46 sigo to bed at 6:00 p.m.	entered unidentified room call light on above door and all light still activated. Observed sitting in his w/c in assistance to bed with call lights activated in hall 200 observed still waiting in his and R54's call lights came on ors. Wheeled himself out of his poking down hallway. RN-A get R46 hooked up to the lift g. was observed sitting in his w/c I-A present hooked up to the alked into R46's room to assist 16 to bed. (R46 waited 41				
	NA-B stated on 11/5/19, at 2:32 p.m. there too many lifts and too many behaviors and not enough staff and that was why some residents had to wait over an hour to get help to get into					
	at the last step of the first and the resider last. NA-B stated the	esidents who needed less care ne process to bed went to bed nts who required more steps here was not enough staff to NA-B stated that was here at the facility.				
	could not be comple	I/6/19, at 2:21 p.m. showers eted when only having two last Sunday only had two NAs				

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AND DIAN OF CORRECTION TO TRENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00758	B. WING			C 1 2/2019
	PROVIDER OR SUPPLIER	FALLS 300 NORT	DRESS, CITY, S TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOOD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 800	and generally couple only two NAs instead he cracked down or lights before assisting R46 gets left to the leave him and since price. LPN-C stated manager aren't ans R46's care plan data R46's preference for RN-A nurse manage p.m. R46 can go to knew that. RN-A statime was not identifing the was not identifing to bed at 6:00 p. DON stated on 11/3 go to bed at 6:00 p. DON stated staff shollow residents' care Facility policy Self Expericipation dated would be allowed to consistent with thei including sleeping. facilitate resident chinformation about reupon initial assess thereafter, and doct the medical record.	le times a pay period ran with ad of three NAs. LPN-C stated in the NAs for turning off calling resident. LPN-C stated end and staff leave tend to e R46 is patient R46 pays the disually the DON and nurse ewering the call lights. Ided 11/7/19, did not include or bedtime at 6:00 p.m. Ider, stated on 11/7/19, at 2:26 bed at 6:00 p.m. and all staff ated R46's preference for bed fied on R46's NA care sheet by word of mouth." In 19, at 2:45 p.m. R46 could m. as it was his preference. Include accommodate this and replan. Determination and 7/25/16, indicated residents or choose schedules that are interest for daily routine. The policy indicated to noices staff would gather esidents' personal preferences ment and periodically ument these preferences in the call Light display and respond to residents' call lights and respond to residents'	2 800			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/1	; 2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	H DOW STR			
		CANNON	FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 36	2 800			
	R7 was observed of in his w/c near front wait for help in the inwrapped and get witransferred him to his stated he asked the at this time but the could not as she waneeded to wrap his legs wrapped when physician had told his wound for his legs than the wound would recognition was intacted diabetes and anxiet R7 needed extensive.	in 11/4/19, at 6:55 p.m. sitting to desk. R7 stated he had to mornings to get his legs ashed up. R7 stated night staff his w/c at about 5 a.m R7 in inght nurse to wrap his legs night nurse had told him she as too busy and the day nurse legs. R7 stated he wanted his in he got up because his him it was better for his leg to be wrapped when getting up all heal faster. Itated 8/1/19, indicated R7's to and included a diagnosis of ty. R7's Annual MDS indicated we staff assistance with all activities of daily living. R7's				
	have compression legs applied in the r	d 6/27/19, indicated R7 was to devices applied to both lower morning and taken off at blan indicated R7 had a lower right leg.				
	was to have "Comp	er dated 11/7/19, indicated R7 pression devices to bilateral applied daily related to lling of fluid).				
	R7 stated on 11/6/19, at 10:23 a.m. his legs had been wrapped that morning at 8 a.m. because of wound assessment completed every Wednesday. R7 stated he wanted his legs wrapped when he got up in the morning.					
		n 11/7/19, at 8:07 a.m. sitting m with his legs unwrapped,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			,
		00758	B. WING			2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS	TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	the nurse had not you his legs should be worked he had to go waiting for 10-15 m minutes later regist R7's room and ask RN-A he needed to R7 was observed of wrapped. R7 stated (LPN)-D had wrapped when the night staff would not had told him the mowounds will go awa RN-A who was also 11/7/19, at 1:37 p.m put on at 5 a.m. eachange it on the treso night shift would shift. RN-A stated stime change. R7 was observed of in his w/c with his lest had asked the nigh nurse to do it earlies stated, "it is not goo to show surveyor a lower left unwrapped up in w/c since 4:30 had not applied leg physician had told has soon as he gets.	ight to be answered. R7 stated vet wrapped his legs and stated wrapped when he got up, and to to the toilet and had been inutes already. Couple tered nurse (RN)-A walked into led R7 what he wanted. R7 told to go to the toilet. In 11/7/19, at 1:33 p.m. legs defice the had wanted his legs inight staff got him up, but the lot, and stated the physician lore he wears the wraps his leg. In nurse manager stated on in. R7 could have his leg wraps che day and stated she would leatment administration record it do it at 5 a.m. instead of day she would talk to R7 about the lot in 11/8/19, at 9:55 a.m. sitting legs not wrapped. R7 stated he left nurse to do it and the day left but it had not happened. R7 lod" lifting up his right pant leg pad with drainage on R7's led leg. R7 stated he had been in any lifting up his right pant leg pad with drainage on R7's led leg. R7 stated his him the wraps were to be on	2 800			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS 300 NORTH DOW STREET CANNON FALLS 300 NORTH DOW STREET CANNON FALLS MM \$5099	AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
CANNON FALLS SUMMARY STATEMENT OF DEFICIENCIES CRANNON FALLS, MN 55009			00758	B. WING			_
CANNON FALLS, MN 55009	NAME OF I	PROVIDER OR SUPPLIER				·	
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) 2 800 Continued From page 38 supposed to wrap R7's legs at 5 a.m. instead of day nurse. LPN-E stated LPN-B (night nurse) had reported to him this morning that she had not wrapped R7's legs because she had not noticed the time change for R7's legs to be wrapped from 7 a.m. to 5 a.m. LPN-E stated he had not wrapped R7's legs today as was not time as was a lot to do and needed to pass the medications first. RN-A, nurse manager stated on 11/8/19, at 12:47 p.m. she was not aware that the night nurse had not wrapped R7's legs last night and stated the night nurse should have since RN-A had changed the time "yesterday" for R7's legs to be wrapped at 5 a.m R7 was observed on 11/8/19, at 12:59 p.m. sitting in his w/c in the hallway with his legs not wrapped R7's legs today and was planning on wrapping R7's legs attent or the dressing change on the leg. NA-J stated on 11/12/19, at 1:33 p.m. R7 had went to a medical appointment this morning at 8:30 a.m. and stated she had helped him get up today. NA-J stated R7 did not have his legs wrapped when he left for his medical appointment at 8:30 a.m. R7 was observed on 11/12/19, at 1:33 p.m. sitting in his w/c in his room with no leg wraps on. R7 stated he had gotten back from his medical appointment at noon today. R7 stated the had gotten back from his medical appointment at noon today. R7 stated he had gotten back from his medical appointment at the noon today. R7 stated he had gotten back from his medical appointment at 8:30 a.m.	THE GAI	RDENS AT CANNON I	FALLS				
supposed to wrap R7's legs at 5 a.m. instead of day nurse. LPN-E stated LPN-B (night nurse) had reported to him this morning that she had not wrapped R7's legs because she had not notloed the time change for R7's legs to be wrapped from 7 a.m. to 5 a.m. LPN-E stated he had not wrapped R7 legs today as was not time as was a lot to do and needed to pass the medications first. RN-A, nurse manager stated on 11/8/19, at 12:47 p.m. she was not aware that the night nurse had not wrapped R7's legs last night and stated the night nurse should have since RN-A had changed the time "yesterday" for R7's legs to be wrapped at 5 a.m R7 was observed on 11/8/19, at 12:58 p.m. sitting in his w/c in the hallway with his legs not wrapped. R7 stated, "They (nurses) probably won't do it now." LPN-E stated on 11/8/19, at 12:59 p.m. he had not wrapped R7's legs today and was planning on wrapping R7's legs today and was planning on wrapping R7's legs after he completed the dressing change on the leg. NA-J stated on 11/12/19, at 9:42 a.m. R7 had went to a medical appointment this morning at 8:30 a.m. and stated she had helped him get up today. NA-J stated R7 did not have his legs wrapped when he left for his medical appointment at 8:30 a.m. R7 was observed on 11/12/19, at 1:33 p.m. sitting in his w/c in his room with no leg wraps on. R7 stated he had gotten back from his medical appointment at noon today. R7 stated the night	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
nurse had told him she was "too busy" to wrap his legs.	2 800	supposed to wrap F day nurse. LPN-E s reported to him this wrapped R7's legs the time change for 7 a.m. to 5 a.m. LP wrapped R7 legs to lot to do and neede RN-A, nurse manage p.m. she was not an ot wrapped R7's lenight nurse should the time "yesterday at 5 a.m R7 was observed on in his w/c in the hall wrapped. R7 stated won't do it now." LPN-E stated on 11 not wrapped R7's legs dressing change or NA-J stated on 11/went to a medical at 8:30 a.m. and state today. NA-J stated wrapped when he leat 8:30 a.m. R7 was observed on in his w/c in his room stated he had gotte appointment at noon nurse had told him	R7's legs at 5 a.m. instead of stated LPN-B (night nurse) is morning that she had not because she had not notice of R7's legs to be wrapped from R7's legs to be wrapped from R7's legs to be wrapped from R7's legs to be medications from R7's legs the medications from R7's legs the medications from R7's legs to be wrapped from R7's legs not legs today and was planning after he completed the from the leg. 12/19, at 9:42 a.m. R7 had appointment this morning at led she had helped him get used she ha	of had ed oom s a a irst. ::47 ad ee ged ed ting if on irst ing it ing i			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00758	B. WING			C 12/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	-ALLS	TH DOW STR			
	T	CANNON	FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 39	2 800			
	have compression of legs applied in the r bedtime. R7's carep venous ulcer on his					
	Director of Nursing (DON) stated on 11/8/19, at 1:02 p.m. R7 was diabetic and was seeing a neurologist for right side numbness. DON stated nurses should follow orders and staff should follow resident care plans. DON stated residents should have preferences and choices honored. DON stated staff had been cut back this year and she had asked the administrator to increase nursing staff. DON stated the administrator wanted her to take another new admission with a trach on the transition care unit and she had told him absolutely not could not admit that complex of resident without increasing staffing first as the acuity on the transition care unit was high already.					
	7/25/16, indicated, should assist reside achieving independ	mmodation of Needs dated facility's staff behaviors ent in maintaining and/or ent functioning, dignity and emmodate residents' individual aces.				
		7/25/16, indicated each allowed to choose schedules				
	Hallway 200 did not a time. NA-J stated hallway 200 but thre everything done that shift. NA-J stated H	12/19, at 9:42 a.m. that thave enough NAs working at three were scheduled on ee were not enough to get at needed to be done on a lallway 200 needed almost NA-J stated residents were				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/1	2/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GAI	RDENS AT CANNON	FALLS	TH DOW STR				
			FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 800	Continued From pa	ge 40	2 800				
	bathing and showe	timely and were not getting ring completed at all.					
	DON stated on 11/8/19, at 1:02 p.m. DON nursing had not completed any audits to determine staff response time for long call light wait time for residents' request for staff assistance.						
	Facility policy undated, Answering the Call Light indicated staff would answer residents' call lights as soon as possible and respond to residents' requests and needs.R46 was observed on 11/4/19, at 6:06 p.m. sitting in his wheelchair (w/c) in his room with his call light lit up above his door.						
	R46's Annual MDS dated 10/4/19, indicated R46's cognition was intact with a diagnosis of paraplegia (paralysis of the lower body). R46's Annual MDS indicated R46 needed Total Dependence two staff assistance with transfers and Extensive two staff assistance with dressing, toileting, grooming, bathing. R46's MDS indicated under Section E- Interview for Daily Preferences was marked (-) for the interview question "How important to choose your own bedtime?"						
	On 11/4/19, at 6:06 p.m. a staff walked by R46's room two times without entering R46's room. -At 6:17 p.m. director of nursing (DON) stood in hallway and told registered nurse (RN)-A to answer R46's call light and to see what R46 needed. RN-A (who was also nurse manager) entered R46's room and exited and left call light on. -At 6:19 p.m. R46 propelled himself in his w/c out his doorway to the hall with his call light on. -At 6:23 p.m. DON said to unidentified nursing assistant (NA), "Whose call light is on?" NA told						

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00758	3. WING		С	
77.75				, 2/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRI	RESS, CITY, S	STATE, ZIP CODE		
THE CARRENG AT CANNON FALLS 300 NORTH	DOW STR	EET		
THE GARDENS AT CANNON FALLS CANNON FA	ALLS, MN	55009		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 800 Continued From page 41	2 800			
DON it was R46 waiting to go to bed but R10's call light was on and she wanted staff assistance as she had opened and spilled a coca cola all over herself and also wanted assistance to go to the toilet. DON told NA to go and hook up R46 to the lift while DON went and told R10 she would be helped after R46 was assisted. -At 6:25 p.m. an unidentified staff walked past R46's room pushing a resident in a w/c without inquiring what R46 needed. At 6:25 p.m. there were four call lights activated on in the 200 hallway while RN-A was seated in her office, and activity staff (ACT)-B and licensed practical nurse (LPN)-C were talking to each other at nurse station. DON told NA-G, "I will meet you in R46's room." -At 6:27 p.m. two unidentified NAs entered R4's room with the transfer lift. -At 6:27 p.m. DON entered R23's room and told R23 she would need to wait and staff would help her to bed "Soon, there are people [residents] ahead of you." -At 6:28 p.m. DON entered R46's room and asked him if he was ready for bed. R46 stated the NAs went into R4's room with the lift. R46 he was tired and wanted to get into bed and my program Chicago PD is coming on television. -At 6:30 p.m. R46's call light over his door went off, DON in R46's room. -At 6:30 p.m. DON exited R46's room and stated to R46 she would see how much longer it would take to get him assistance to bed. -At 6:30 p.m. R29 was observed sitting in his w/c at nurse station yelling, "Help! Help!" -At 6:30 p.m. DON entered unidentified room number which had call light on above door and exited room with call light toil activated.	2 800			

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light on.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00758		B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS	300 NOR	DRESS, CITY, S TH DOW STR FALLS, MN		·	
(X4) ID PREFIX TAG	l l	ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN	IENCIES DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	-At 6:33 p.m. no ca -At 6:33 p.m. R46 or room to go to bed. -At 6:38 p.m. R10 a over their room doo -At 6:40 p.m. R46 or room into hallway lot told R46 she could while he was waitin -At 6:44 p.m. R46 or in his room with RN transfer lift. -At 6:47 p.m. NA w RN-A to transfer Reminutes for staff as -At 7:18 p.m. R46 or go to bed at 6:00 p he "waits that long the usual."	and R54's call lights activate observed still was and R54's call lights. Wheeled himself ooking down hat get R46 hooked g. Was observed si N-A present hoo calked into R46's 46 to bed. (R46 to sistance). Stated to survey m. every eveninall the time to g	ghts came on f out of his Ilway. RN-A d up to the lift itting in his w/c ked up to the s room to assist waited 41 or he wants to ng. R46 stated o to bed, it's m. there too	2 800			
	many lifts and too renough staff and the had to wait over an bed. NA-B stated reat the last step of the first and the resider last. NA-B stated the wash residents up. generally the norm LPN-C stated on 10 could not be compled NAs. LPN-C stated and generally coup only two NAs instead he cracked down of lights before assist R46 gets left to the leave him and since	many behaviors nat was why son hour to get helpesidents who need process to be not some was not en NA-B stated the here at the facion less that Sunday on the NAs for turing resident. LP end and staff less when end staff less when safe to the less was not en the less when the less was not en the less was not en the less was not end and staff less was not end and staff less when was not end and staff less was not end and sta	and not ne residents p to get into eeded less care ed went to bed d more steps ough staff to at was lity. b.m. showers having two ly had two NAs period ran with LPN-C stated urning off call N-C stated eave tend to				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00758	B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS 300 NO	ADDRESS, CITY, S RTH DOW STR	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800	price. LPN-C stated manager aren't ans R46's care plan dat R46's preference for RN-A nurse manage p.m. R46 can go to knew that. RN-A statime was not identifing the was not identifing to be at 6:00 p. DON stated staff slated follow residents' car a Facility policy Self I Participation dated would be allowed to consistent with their including sleeping. Facilitate resident of information about rupon initial assess thereafter, and doc the medical record. Facility policy undarindicated staff would as soon as possible requests and needs	d usually the DON and nurse swering the call lights. ted 11/7/19, did not include or bedtime at 6:00 p.m. ger, stated on 11/7/19, at 2:26 bed at 6:00 p.m. and all staff ated R46's preference for bedfied on R46's NA care sheet by word of mouth." 7/19, at 2:45 p.m. R46 could .m. as it was his preference. hould accommodate this and replan. Determination and 7/25/16, indicated residents or choose schedules that are residents for daily routine. The policy indicated to hoices staff would gather esidents' personal preferencement and periodically ument these preferences in ted, Answering the Call Light danswer residents' call lights and respond to residents'	es s			
	in his w/c near fron wait for helpin the r wrapped and get w transferred him to h	on 11/4/19, at 6:55 p.m. sitting t desk. R7 stated he had to mornings to get his legs ashed up. R7 stated night sta nis w/c at about 5 a.m R7 e night nurse to wrap his legs	ıff			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00758	B. WING		11/1	; 2/2019
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	•	
THE GARDENS AT CANNON FA	ALLS	FALLS, MN			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
could not as she was needed to wrap his le legs wrapped when he physician had told him wound for his legs to and the wound would R7's Annual MDS da cognition was intact a diabetes and anxiety R7 needed extensive dressing and with all MDS indicated R7 did R7's careplan dated have compression de legs applied in the me bedtime. R7's careplan venous ulcer on his legs applied in the me bedtime. R7's careplan venous ulcer on his legs applied in the me bedtime. R7's careplan venous ulcer on his legs applied in the me bedtime. R7's physician order was to have "Compression or lower extremities" applied by the compression of the wasted on 11/6/19 been wrapped that me wound assessment of R7 stated he wanted got up in the morning R7 was observed on in his w/c in his room waiting for his call light the nurse had not yet his legs should be wristated he had to go to waiting for 10-15 min	ight nurse had told him she is too busy and the day nurse egs. R7 stated he wanted his he got up because his im it was better for his leg is be wrapped when getting up disheal faster. Inted 8/1/19, indicated R7's and included a diagnosis of it. R7's Annual MDS indicated it staff assistance with activities of daily living. R7's id not reject cares. 6/27/19, indicated R7 was to evices applied to both lower forning and taken off at an indicated R7 had a ower right leg. dated 11/7/19, indicated R7 ession devices to bilateral oplied daily related to ing of fluid). 2), at 10:23 a.m. his legs had norning at 8 a.m. because of completed every Wednesday. I his legs wrapped when he	2 800			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		С	
		00758	B. WING			2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS	TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	nge 45	2 800			
	R7's room and asked R7 what he wanted. R7 told RN-A he needed to go to the toilet.					
	wrapped. R7 stated (LPN)-D had wrapped 10:15 a.m. R7 stated wrapped when the night staff would not had told him the mounds will go award RN-A who was also 11/7/19, at 1:37 p.m. put on at 5 a.m. eachange it on the treso night shift would shift. RN-A stated state	on 11/7/19, at 1:33 p.m. legs dicensed practical nurse bed his legs this morning at ed he had wanted his legs night staff got him up, but the ot, and stated the physician ore he wears the wraps his ey. In onurse manager stated on m. R7 could have his leg wraps ch day and stated she would eatment administration record do it at 5 a.m. instead of day she would talk to R7 about the				
	in his w/c with his le had asked the nigh nurse to do it earlie stated, "it is not goo to show surveyor a lower left unwrappe up in w/c since 4:30 had not applied leg physician had told las soon as he gets	on 11/8/19, at 9:55 a.m. sitting egs not wrapped. R7 stated he t nurse to do it and the day or but it had not happened. R7 od" lifting up his right pant leg pad with drainage on R7's ed leg. R7 stated he had been 0 a.m. this morning and nurses wraps. R7 stated his him the wraps were to be on up for the day.				
	11/8/19, at 10:03 a supposed to wrap I day nurse. LPN-E s reported to him this wrapped R7's legs the time change for	.m. the night nurse was now R7's legs at 5 a.m. instead of stated LPN-B (night nurse) had a morning that she had not because she had not noticed at R7's legs to be wrapped from N-E stated he had not				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
			A. BOILDING.				
00758		00758	B. WING		1	<i>,</i> 2/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STR				
CANNON		CANNON	FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 800	Continued From pa	ge 46	2 800				
		day as was not time as was a d to pass the medications first.					
	p.m. she was not a not wrapped R7's le night nurse should	ger stated on 11/8/19, at 12:47 ware that the night nurse had egs last night and stated the have since RN-A had changed " for R7's legs to be wrapped					
	R7 was observed on 11/8/19, at 12:58 p.m. sitting in his w/c in the hallway with his legs not wrapped. R7 stated, "They (nurses) probably won't do it now."						
	LPN-E stated on 11/8/19, at 12:59 p.m. he had not wrapped R7's legs today and was planning on wrapping R7's legs after he completed the dressing change on the leg.						
	went to a medical a 8:30 a.m. and state today. NA-J stated	12/19, at 9:42 a.m. R7 had ppointment this morning at d she had helped him get up R7 did not have his legs eft for his medical appointment					
	in his w/c in his root stated he had gotte appointment at noo	n 11/12/19, at 1:33 p.m. sitting m with no leg wraps on. R7 n back from his medical n today. R7 stated the night she was "too busy" to wrap his					
	have compression legs applied in the r	d 6/27/19, indicated R7 was to devices applied to both lower morning and taken off at blan indicated R7 had a lower right leg.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
74401044	OF CONTROL OF THE CON	BENTI TOXTTON NOMBER.	A. BUILDING:			
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALIS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	1:02 p.m. R7 was oneurologist for right nurses should follow follow resident care should have prefere DON stated staff has he had asked the nursing staff. DON wanted her to take trach on the transiti him absolutely not of resident without acuity on the transit him absolutely not of resident without acuity on the transit him absolutely not of resident without acuity on the transit him absolutely not of resident without acuity on the transit him absolutely not of resident without acuity policy Acco 7/25/16, indicated, should assist reside achieving independ well-being and acconneeds and preferer. Facility policy Self I Participation dated resident should be with times of days for NA-J stated on 11/1 Hallway 200 did not a time. NA-J stated hallway 200 but threeverything done that shift. NA-J stated hour NAs on a shift not getting toileted bathing and shower DON stated on 11/8	(DON) stated on 11/8/19, at diabetic and was seeing a t side numbness. DON stated worders and staff should eplans. DON stated residents ences and choices honored. ad been cut back this year and administrator to increase stated the administrator another new admission with a ion care unit and she had told could not admit that complex increasing staffing first as the tion care unit was high already. In maintaining and/or dent functioning, dignity and formodate residents' individual for the tion care unit was high already. Determination and 7/25/16, indicated each allowed to choose schedules for treatments. 12/19, at 9:42 a.m. that thave enough NAs working at three were scheduled on the were not enough to get at needed to be done on a deallway 200 needed almost. NA-J stated residents were timely and were not getting ring completed at all.	2 800			
		mpleted any audits to ponse time for long call light				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					_ c	
		00758	B. WING		11/1	2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS	TH DOW STR FALLS, MN			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 48	2 800			
	wait time for reside assistance.	nts' request for staff				
	Facility policy undated, Answering the Call Light indicated staff would answer residents' call lights as soon as possible and respond to residents' requests and needs.					
	R15's face sheet indicated admission date of 11/26/18, with diagnosis of Alzheimer's disease, dementia with behavioral disturbance, anxiety disorder, affective mood disorder, major depressive disorder, pseudobulbar affect (inappropriate involuntary laughing or crying) and impulsiveness.					
	R15's quarterly MDS dated 8/22/19, indicated Brief Interview for Mental Status identified R15 had severe cognitive impairment. R15 wandered 1-4 days during assessment period, needed supervision with bed mobility, ambulation and eating. R15 required extensive assistance with dressing, toileting and personal hygiene. R15 took an antipsychotic, antidepressant and diuretic medication daily.					
	indicated R15 requi wanting to leave the R15 had severe co	essessment dated 12/7/18, ired a secured unit due to her to facility and her memory loss. In gnitive impairment and was what others were saying and d.				
	R15 had the potent related to dementia R15 was bothered independent with a	nted on 11/6/19, indicated ial to be physically aggressive, and poor impulse control. by loud noises. R15 was mbulation and transfers. led: When R15 became				

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agitated to intervene before agitation escalates,

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		_ ا	
		00758	B. WING		11/1	, 2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	H DOW STR			
		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 CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 49	2 800			
2 000	and guide away fro document any signs or others; Staff to bunit and keep R15 invade her personal needed; Redirect wat risk for doing sor distress; Monitor particular occurrences. Review of Daily State 2019, revealed that	m source; Monitor and s of R15 posing danger to self the aware of R15 activity on the from residents that tend to all space; Cue and supervise as when R15 seems confused or mething that might cause acing, wandering or crying affing Sheets since July of the 300 memory unit was and evening shift with two staff	2 000			
	Vulnerable Adult (Vithat R15 had four a with physical aggre-On 7/27/19, R15 waround R57's neck in the arm before sindicated that consiresidents and their everyone safe and On 9/19/19, R15 aunsupervised when (LPN) heard screar got within eye sight punching each otheindicated that the sithe time of the alter-On 10/11/19, R55 near the exit door walk up behind R55 seen to get up from pushing R15 before-On 10/22/19, R55 and R15 walked up	and R55 were identified as a licensed practical nurse ming and swearing. When LPN as she found R15 and R55 er in the face. The report also econd staff was off the unit at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00758	B. WING			C 12/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
THE GA	RDENS AT CANNON I	FALLS	TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 800	with her open hand On 11/4/19, at 1:17 sitting at the table in present. At 1:20 p.r (LPN)-F entered the got up and walked room. The commor three minutes wher On 11/4/19, at 5:21 sitting at a table yel table walked over the about a fist in yexactly what she sat There were no staff where these two rekitchen staff entere by a direct care star unsupervised for for On 11/4/19, at 5:31 walking around and resident's hair who was no staff preser was an activity staff another resident but At 5:39 p.m., the accommon area where common area was On 11/5/19, at 8:08 assistant (TMA)-A sand asked LPN-A for common area where assisted the other sare turned to common residents sitting at the were unsupervised	before staff could intervene. p.m. R15 was observed n common area with no staff n. licensed practical nurse e common area just as R15 down the hall to go enter a n area was unsupervised for e R15 was sitting. p.m. R33 was observed ling and R15 got up from her o R33 and stated something to our nose (unable to identify id) then returned to her table. If present in the common area sidents were. At 5:25 p.m. d the common area followed ff. The common area was				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00758		B. WING		11/1) 2/2019
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALLS	H DOW STR			
	OLIMANA DV. OTA		FALLS, MN		ON.	4>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 51	2 800			
	residents including R15. At 8:30 a.m., kitchen staff arrived to common area. The common area was unsupervised for eight minutes.					
	walking down the h another resident ro- in the common area	3 a.m. R15 was observed allway and both staff were in om. There was an activity staff a but this staff was unable to do her whereabouts.				
	with residents (inclute the other staff in a r	a.m. LPN-K left common area uding R15) present to assist room. At 7:56 a.m, LPN-K mon area having left the area we minutes.				
	On 11/8/19, at 7:58 a.m. both staff are observed to go into a resident room leaving five residents including R15 unattended within the common area and hallway. At 8:03 a.m. TMA-B came out of room to common area that had been left unsupervised for six minutes.					
	stated that R15 alw and someone need that the nurse had i memory unit and th alone at times and everyone. NA-D sta assistance with a re	11/4/19, at 5:25 p.m. NA-D rays had aggressive behaviors led to watch her. NA-D stated medications to give on the re 200 wing so that left NA-D it was very hard to monitor ated that when she needs resident the nurse was the one rifies that the residents were uring those times.				
	indicated monitoring as R15 was very ke TMA-A stated "we d	11/5/19, at 8:53 a.m. TMA-A g R15 included watching her een on another male resident. cannot monitor all the are in getting residents up"				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00758		B. WING			C 12/2019
	THE GARDENS AT CANNON FALLS 300 NOR			DRESS, CITY, STH DOW STR			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		DEFICIENCY MUST BE PRECEDED BY FULL PRI		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 800	The activity director 11/6/19, at 10:20 at department did not memory unit. AD st called to assist with memory unit while sit was not part of the The assistant direct interviewed on 11/6 indicates that R15 I she lashed out unpount an eye on R15 be always in eye significant to be in a staff need to be in a staff need to come, someone monitoring other residents with R15 continued to he	r (AD) was intervied m. and stated that have set hours on ated the activity state monitoring reside staff were complete activities daily duter of nursing (ADO) 19, at 10:45 a.m. and quite a few incrovoked. ADON states and R15 was suight of staff. ADON a room and could reproperly needed to radias there needed to gat all times as the behaviors. ADON	t the activity the aff were not ents on the ing cares as uties. ON) was and cidents when cated staff pposed to stated if not monitor io for o be here were I agreed that	2 800			
	altercations with no was unsure if anyon altercation happened pattern. During interview on indicated R15 was on one to one super have those resource residents on that un assistance and dur radio call for assistance acceptation that residents on that residents on that un assistance and dur radio call for assistance and call for assistance acceptation that residents on that residents on the common area. On 11/6/19, at 2:09 should have always view of the hall and	ne had looked at the doto see if there we are 11/6/19, at 11:12 to be monitored but rision as the facilies. DON stated the interest that required twing those times stance to monitor report to monitor report it was sidents were not less been one staff with the p.m. RN-A indicates been one staff with the control of the co	a.m. DON ut was not ity did not ere were o staff aff had to sidents in her ift alone in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
		00758	B. WING		11/1	2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	-ALLS	TH DOW STR			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	FALLS, MN	PROVIDER'S PLAN OF CORRECTION	 ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 800	Continued From pa	ge 53	2 800			
	the nurse went to g	mes that did not happen as ive pills but that was why staff ey can ask for help.				
		a.m. licensed social worker spected to be with R15 when mon area.				
	had to watch the re	p.m. NA-I stated someone sidents when they were in the times because "you never do."				
	Review of undated, Resident to Resident Altercation policy identified staff were to monitor residents for aggressive or inappropriate behaviors towards others.					
	Procedure indicated measures to address minimize the possible Prevention Program committed to protect policy also indicated and patterns of potes.	19, Abuse Policy and distaff were to institute as the needs of residents to bility of abuse. The Abuse in section indicated staff were carresidents from abuse. The distaff will identify occurrences and implement future occurrences.				
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and e; General	2 830			12/29/19
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a				

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WIIIIII	na Department of Tie	ailii				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						2
		00758	B. WING			2/2019
	200/4050 00 011001150	OTDEET AD		71.75 715 0055	<u>' </u>	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAI	RDENS AT CANNON F	FALLS	TH DOW STR			
		CANNON	FALLS, MN	55009		
(X4) ID		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG	\	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
		·		DEFICIENCY)		
2 830	Continued From po	go 54	2 830			
2 000	Continued From page 54		2 030			
	written order from the	he attending physician that the				
	resident must rema	in in bed or the resident				
	prefers to remain in	bed.				
	This MN Poquirom	ant is not mot as avidanced				
	This MN Requirement is not met as evidenced					
	by: Based on observation, interview and document			Corrected		
	review, the facility failed to ensure heat registers			001100100		
		safe temperatures in resident				
		esidents (R29) with baseboard				
		o promptly respond to 1 of 1				
	resident (R44) repo	rt of shortness of breath,				
		uest to be transported to an				
		or evaluation. In addition, the				
		prehensively assess				
		falls and develop and				
		ate interventions for 1 of 3				
		ewed for falls and failed to				
		ents for 1 of 1 resident (R7) leg wraps for lymphedema.				
	The facility also faile					
		eassess continued use of a				
		wing a change in mobility and				
		ns for 1 of 1 resident (R30)				
		. Additionally, the facility failed				
		on to reduce resident to				
		s for 5 of 5 residents (R15,				
	R33, R55, R56, R5	7) in the memory unit.				
		cility failed to assess, develop				
		nterventions to promote safe				
		ge practices for 2 of 2				
		5) reviewed for smoking				
		form leg treatments for 1 of 1				
		luled for daily leg wraps for				
	lymphedema.					
	Findings include:					
	i mamga moluuc.					

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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GA	RDENS AT CANNON I	FALLS	TH DOW STR			
	OUR MAR DV OTA		FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 55	2 830			
	(MDS) assessment severe cognitive im R29's Significant Clarequired extensive amobility, transfers, a diagnoses were identype 2 diabetes, del R29's 11/6/19, care self-care deficit related cognitive loss assowns weakness, and incomposition in bed, extensive assistant reposition in bed, extensive assistant reposition in bed, extensive assistant required extensive assistant required extensive associated with der associated with der An incident report dindicated R29 had as The incident report the lowest position contact with the elethe resident sustain incident report, the determined the hear cycle. Further the many reported at the time was cool to the touch R29's progress note indicated R29 was a leg against the hear progress note indicated recognitions.	ated to cognitive loss mentia. lated 11/1/19, at 4:30 p.m, sustained a burn to his left leg. indicated R29's bed was in next to the wall and was in ctric baseboard heater when led the burn. According to the maintenance director (M) had ter had an intermittent heating naintenance director had e of his inspection, the heater				

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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00758	B. WING		11/1	; 2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THECA	DENC AT CANNON I	300 NOR1	TH DOW STR	REET		
THE GAI	RDENS AT CANNON I	CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	outer aspect of the staff had applied a addition, R29 was ralert with no signs of subsequently contare order for Silvadine immediately moved heater. The Admini (DON) and M had obeen on long enougheating cycle. Followere checked to endirectly against wall was provided to keel in addition, the mai responsible to over monitoring of the whours. R29's physician providentified R29 sustaleft lower leg. Staff cream twice daily a and covered. Observation on 11/R29's electric heate exterior window alouring observation 2:29 p.m. with M-A, be an electric based outer surface. At the internal temperature measured by M-A with the two surfaces in the staff counter surface. At the internal temperature measured by M-A with the two surfaces in the staff counter surface. At the internal temperature measured by M-A with the surfaces in the staff counter surfaces in the staff counter surface. At the internal temperature measured by M-A with the staff counter surfaces in t	ge 56 left lower leg and indicated cold compress to the area. In noted by staff to have been of pain. R29's physician was cted and staff received an (burn cream). R29's bed was a away from the wall with the strator, the director of nursing determined the heater had gh to expose R29's skin at the wing the incident, all rooms assure beds were not placed. I heaters, and staff education ap R29 away from the heater. Intenance director was see periodic temperature all heaters for the next 24. Signess note dated 11/4/19, ained a 2nd degree burn to the were to continue Silvadine and to keep the wound clean. 5/19, at 1:34 p.m. identified ar was located under an ang the floor baseboard. and interview on 11/5/19, at R29's heater was observed to board heater with a metal at time, the surfaces and and a of R29's heater were with an infrared thermometer cahrenheit (F) on the outer op of the heater measured 119	2 830	DEFICIENCY		
	123 degrees F. M-A	internal heating element was A agreed residents with fragile of for accidental burns when in				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						,
		00758	B. WING		1	, 2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
THE GAR	RDENS AT CANNON I	FALLS	TH DOW STR			
		CANNON	FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	 ige 57	2 830			
2 830	close contact with thad determined R2 irradiation from the exiting the vent. Mincident, he had che and 200 wings to endirect contact with the stated he thought in heater surface had 135 degrees F, and with the heater for a M-A was unaware or regulatory guidance sustained after exp 120 degrees F in exunable to find a maany of the heaters to recommendations for the heaters had be years. M-A further a were not checked from the fall of the year had not been reminitems off, or away for had monitored the following the burn, surface temperature. During interview on assistant (NA)-B state concern related to manager, registered.	the heater. M-A stated they 19's burn was caused by heated air inside the heater, A said following R29's ecked all rooms on the 100 nsure no other beds were in those types of heaters. M-A n order to cause a burn, the to reach between 133 and diskin needed to be in contact an extended period of time. Of the direction in the extended to be the theoretical to the direction in the extended period of time. Of the direction in the extended period of times of the direction in the extended period of times. M-A was anufacturer or serial number for to determine manufacturer's for safe heater use, and stated the in use for at least 30 to 40 acknowledged the heaters for safety prior to the initial use for a safety prior to the initial use for an addition M-A verified staff anded to move any beds or from, heaters. M-A stated he temperatures of the room but had not monitored heater	2 830			
	said he had raised higher than the floo but stated he had n the heater on the wadvised him to place	the close to the heater. NA-B the bed up a couple inches or because the heater was hot, not moved the bed away from vall. NA-B said RN-A had be R29's bed in the lowest beknownst to staff, put R29 in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	H DOW STR			
	0.10.00.40.4		FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 58	2 830			
	contact with the hear measured the tempafter the incident ar heaters above 120 remember which ro	ater. NA-B stated he perature of all the room heaters and found 4 or 5 of room degrees but was unable to				
	10:13 a.m. licensed stated R29's bed when the heater at the tine the burn was initiall blister however, R2 result of the burn. It of the interview, the appeared as an irrewith bright red marg 90 percent (%) contissue, and the outer beefy red.	I practical nurse (LPN)-E as in the low position next to the of the burn. LPN-E stated by a large dark red area with no go developed a blister as a During observation at the time burn on R29's left lower leg agular 5 cm by 3 cm wound gins, with the inner wound bed wered with greenish/yellower 10 % of the wound bed was				
	a.m. said he had n R29 was unable to	th R29 on 11/7/19, at 10:15 o pain in his lower left leg. recall the events surrounding e of person only, and was not ed further.				
	denied being aware the heater tempera no documentation of hot. DON confirmed been monitored init stated she expected and stated staff we next to the heater a DON stated she wa had received educa policy was not revise	11/8/19, at 2:10 p.m. DON e staff were concerned about tures. DON stated there was of heater surfaces being too d the heater temperatures had ially after the burn. DON d all rooms to be monitored re educated not to put beds fter R29's burn. However, as unable to verify which staff ation, and verified the revised ewed after R29's incident.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00758	B. WING		11/1	2/2019
	PROVIDER OR SUPPLIER	300 NOR	DRESS, CITY, S	STATE, ZIP CODE		
THE GA	RDENS AT CANNON I	-ALLS CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	identified staff on dikeep beds away frowas no evidence to were not on duty at been educated on he deep beds away frowas no evidence to were not on duty at been educated on he deep beds a director (Moresident had received of the circumstance old, but replacing the option. However, comeasures and policiparevent burns from facility to develop a around heaters to keep out of the established burns and expected provide training to a service of the facility. Temperature Policy items were to be keep baseboard heaters did not identify what temperature was, be to be brought to ma R44's Diagnoses Review of the facility of th	uty had received education to am the heaters however, there determine whether staff who the time of the incident had neater safety. 11/8/19, at 10:23 a.m. the D) stated he was aware a ed a burn, but was not aware es. MD stated the building was ne heaters was likely not an onfirmed preventative sies should be in place to heaters. He expected the policy to establish a safe-zone neep all beds, sheets, chairs ed safety zone to prevent the management team to all staff about heater safety. by's 12/1/17, Room of identified resident beds and ept a safe distance from the to prevent hazards. The policy that a safe distance or safe ut indicated all concerns were an agement. eport printed on 11/7/19, of sepsis, pneumonia, mary tract infection (UTI) on that diagnoses of bipolar pression Disorder, anxiety ess and agitation, dementia urbance, obesity, neuropathy, dineuropathy of the lower atic and splenic cysts, and a y embolism, lower extremity	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GA	RDENS AT CANNON I	FALLS	TH DOW STR FALLS, MN			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 60	2 830			
	R44's quarterly Min 10/7/19, identified F moderate depressive care on a daily basi assistance of one s required extensive transfer and toilet a setup for eating. R4 frequently and recemedications. R44 h five feet seven inch pounds. R44 used and diuretic medications.	imum Data Sheet (MDS) on R44's cognition was intact, had on, was delusional and towards others, and rejected s. R44 required extensive taff for bed mobility, He assistance of two staff to nd required supervision and 14 had pain rated 5/10 ived scheduled pain ad severe obesity and was es tall and weighed 272 antipsychotic, antidepressant, itions.				
	assistance of two s bed. R44 used a futwo staff to transfer during meals and s R44 had verbally ald demanding, refused coping skills. Staff a cares, allowed time had impaired thoug were to keep consist as much as possible many choices as poinclude intervention hospitalization for pand interventions we use of antibiotic treation of 10/29/19, R44's identified on 10/26/hospital through the diagnosed with pnethis temperature spi	ntified R44 required taff to turn and reposition in all body lift and assistance of . R44 required supervision at in the assisted dining room. Dusive behaviors, was discares, and had ineffective anticipated needs, explained to process information. R44 htt processes. Interventions attent routines and caregivers e, and provide R44 with as assible. The care plan did not is to address recent incumonia, UTI and sepsis, were not included for continued attent. Thospital discharge note 19, R44 was admitted to the e ED for hypoxemia and was umonia. Later the same day ked and blood cultures were ulture identified a UTI, and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS	H DOW STR			
			FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 61	2 830			
	on 10/29/19, includ tablet 2 times daily	ed Augmentin 875-125 mg 1 for 10 days; and Levaquin e morning for pneumonia for 9				
	(EMAR) included no needed with cares, oxygen saturation,	ediation administration record ursing orders to assist R44 as and monitor vital signs with lung sounds, pain, behaviors, pation. The order was /6/19.				
	licensed practical n worked the night she documentation from resident fall, and the used the call light of Throughout the nig complained of short pain. Staff continue to keep him comfort the head of the bed R44's oxygen satur R44 oxygen was not oxygen level was not could be detriment and visible signs of reassured him he with wheezy, but had be hospital, and currer did not contact the he frequently components pain, and had his vital signs were and his oxygen satulimits. She passed oncoming nurse during the side of th	in 11/7/19, at 7:43 a.m. the urse (LPN)-B stated she nift. She was completing her in the night shift she had a enight was very hectic. R44 ver 20 times during the shift. In the was anxious, and the the same and the soft of the the the was anxious, and the soft of the				

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		00770	B. WING			
		00758	B. WING		11/1	2/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	was seated in the disocial worker (SW) stated good mornin was fine, and declir had no signs of short signs of anxiety. On 11/7/19, at 12:1 resident was observed gurney out of the 20 crew. On 11/7/19, at 12:5 was transported to (ED) at 12:57 p.m. pain, shortness of the sounds. He request oxygen was at 94% pain during the night morning, he went to complain of any syr stated he was not free ting. After breakf toileted him. His his was given a nebuliz which was ineffective he was transferred his symptoms. He has symptoms through illness, and was take following his hospitate Expiratory wheezes.	ining room eating breakfast. A was visiting with him. He g, and good bye, he stated he led to be interviewed. R44 ortness of breath, and had not be being transported on a loo wing by an ambulance 7 p.m. LPN-D identified R44 the emergency department following complaints of chest oreath and wheezy lung led to go to the ED. His led to go to the ED. His led to go to the worke up the loo the dining room and did not inptoms. During breakfast, he leeling well but wanted to finish ast, staff laid him down, and a vital signs were checked. He let treatment at 10:48 a.m. It is seen to the ED to further evaluate land complained of all of these the current course of his ling Levaquin and Augmentin alization for pneumonia. It were always present.		DEFICIENCY)		
	11/7/19 did not inclu	ogress notes on 11/6/19 and ude documentation of R44's n, wheezy lung sounds,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
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		00758	b. WING		11/1	2/2019
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 63	2 830			
	request for oxygen, hospital.	or request to go to the				
	identified R44 return	11/8/19 at 10:50 a.m. LPN-D ned from the ED yesterday, hours. He had no new issues,				
	(DON) was notified and instructed LPN was not aware R44 shortness of breath expected staff to cothe hospital as soor chest pain and shortness by MD Tuesda increased his nebul history of shortness bypass. Since his a weight had increased The physician was pneumonia along with shortness of breath DON when he had call her and the phyhealth status occur or concerns regarding	p.m. the director of nursing of R44's change in condition and the condition and chest pain, anxiety, and during the night. She contact her and initiate transfer in possible if residents have the contact her and initiate transfer in possible if residents have the contact her and initiate transfer in possible if residents have the contact have th				
	on 11/8/19, at 2:00 with the DON, and The facility's Chang Status policy (no da supervisor or charg resident's attending including a change been a significant of	from 11/7/19, was requested p.m. following an interview not received for review. The in a Resident's Condition or ste), indicated the nurse enurse was to notify the physician of changes in condition when there has change in the resident's mental status and if there was				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED
	С
00758 B. WING	11/12/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE GARDENS AT CANNON FALLS 300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN O PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AG TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETE DITHE APPROPRIATE DATE
a need to transfer the resident to a hospital or treatment center, or if a physician provided instructions to be notified of changes in a resident's condition. Except in emergencies, notifications were expected to be made within 24 hours of a change occurring in a resident's medical/ mental condition or status. The charge nurse was expected to document information relevant to the resident's physical or mental condition in the resident's medical record. R30 was interviewed on 11/4/19, at 2:13 p.m. and stated in February 2019, he fractured his leg following an accident with his electric scooter. R30 explained his fractured leg had a cast which was heavy and during a mechanical lift transfer his leg was 'dropped' which resulted in an unavoidable knee fracture due to having had cancer in his leg. R30 stated when his leg was in the cast staff had a difficult time transferring him while providing support to his casted leg. R30 was observed on 11/4/19, at 2:13 p.m. lying in his bed with two bilateral leg amputations and unable to use upper extremities. R30 was observed to use his head and mouth to activate his call light and answer his telephone. R30's Discharge Summary dated 2/15/19, identified R30 was hospitalized for a left lower extremity fracture and a left lower extremity splint was to be worn. The facility investigative file dated 3/2/19, identified R30 had a knee immobilizer on his left leg due to prior accidental fracture, however R30 went to the hospital related to complaints of chest pain while at the hospital R30 was found to have had a "fracture by knee." The file indicated this was confirmed as a "new extension of the	

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE COMP	
		00758	B. WING		11/1	; 2/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 11/1	2/2010
THE GAR	RDENS AT CANNON I	FALLS	H DOW STR			
		CANNON	FALLS, MN		ON.	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 65	2 830			
	"his leg was hit on to (NA) reminded to how support during transwas one of the NA during that time. R30's incident reported "the staff whose one staff was sit up straight the ore."	R30 indicated on 3/5/19, that the lift" and nursing assistants andle R30's left leg to ensure sfers. The file identified NA-K who had worked with R30 art dated 3/2/19, indicated R30 was transferring him in the in the back helping resident ther staff guiding resident's that the nursing assistant				
	guiding his legs dro	opped his leg, causing pain." Medicine Provider Note dated				
	left leg pain and wa	30 was seen for complaints of its diagnosed with a fractured ted surrounding sclerosis as				
	had intact cognition included quadripleg	dated 9/16/19, identified R30 and diagnoses which gia and anemia. The annual required total dependence for				
	was totally depende	rised 9/17/19, identified R10 ent on staff for all cares and ovide assist of two staff with full ransfers.				
	R30 had diagnoses	port dated 11/8/19, indicated which included squamous kin of left lower limb, right and nee amputation.				
	reassessment of tra	rd lacked evidence of ansfers with the mechanical lift ver extremity fracture on				

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Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
						;
		00758	B. WING		1	2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TUE 041		300 NOR	TH DOW STR	REET		
THE GAI	RDENS AT CANNON F	-ALLS CANNON	FALLS, MN	55009		
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
2 830	Continued From pa	ge 66	2 830			
	and stated it was he communicate when	ed on 11/8/19, at 1:20 p.m. er expectation for staff to a resident transfers were dent would be reassessed for and lift use.				
	at 4:17 p.m. and sta another NA transfel NA-K recalled he w another NA was ho had his leg in a larg the transfer having brace and the supp NA-K stated during hit his leg on the lift his leg positioned on on when up in the li indicating his leg hu lift. NA-K was unab	red via telephone on 11/12/19, ated he had assisted with R30 with the mechanical lift. as controlling the lift while lding R30's leg due to R30 e brace. NA-K remembered been difficult due to R30's leg ort needed for R30's leg. the transfer R30 "accidentally" as R30 was unable to keep omfortably with the leg brace ft. NA-K remembered R30 art from hitting his knee of the le to recall if the nurse was 130's leg hitting the lift and/or				
	regarding R30's difference of the facility Safe Lifterence of Residents Policy unsafety, dignity, commould be incorporate regarding the safe In The policy indicated resident needs for the completed on an ordocument resident in the care plan. The assessment would assistance, resident resident size, weigh status, if the resider and resident goals.	ting and Movement of adated, indicated resident fort and medical condition ted into goals and decisions ifting and moving of residents. If assessments of individual ransfer assistance was agoing bases and staff would transferring and lifting needs e policy indicated the include resident preference for t degree of dependency, at bearing ability, cognitive the was cooperative with staff Furthermore, safe lifting and ents was part of an overall				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED	
						С	
		00758	B. WING			12/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
THE GA	RDENS AT CANNON	FALLS	TH DOW STF FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
2 830	safety program whi identifying problem R7's Fall Risk Asse indicated R7 was a R7's Quarterly MDS R7's cognition was than two times sinc completed on 8/1/1 indicated R7 had digeneralized muscle MDS indicated R7 in assistance with transiving and did not realized muscle MDS indicated R7 in assistance with transiving and did not realized muscle MDS indicated R7 in assistance with transiving and did not realized muscle MDS indicated R7 in assistance with transiving and did not realized muscle MDS indicated R7 was observed on his wheelchair (work in his room wheel had to go to the later Registered nuwith an EZ stand (in R7 was observed on which in his room with an EZ stand (in R7 was observed on which in his room with an EZ stand (in R7 was observed on which in his room with an EZ stand (in R7 was observed on which in his room with an EZ stand (in R7 was observed on which in his room with an EZ stand (in R7 was observed on which is room with an EZ stand (in R7 was observed on which is room with an EZ stand (in R7 was observed on which is room with an EZ stand (in R7 was observed on which was read unsure.)	ch involved employees in areas. essment dated 10/27/19, High fall risk. 6 dated 10/28/19, indicated intact and had fallen more e the last assessment 9. R7's Quarterly MDS agnoses which included weakness and anxiety. R7's needed extensive staff asfers and all activities of daily	2 830	DELIGIENCI)			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′			LETED
			, BOILBING.			_
		00758	B. WING		11/1	<i>2</i> /2019
		00756			1 11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	THE GARDENS AT CANNON FALLS		TH DOW STR			
		CANNON	FALLS, MN	55009		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
				DEFICIENCY)		
2 830	330 Continued From page 68		2 830			
2 000	Continued From pa	ge oo	2 000			
		n 11/12/19, at 1:33 p.m. sitting				
		m not sitting upright, leaning				
		reaches for things and slides his knees on the floor and				
	-	otten hurt from it. R7 stated he				
		he reacher. R7 stated he				
		eping in his w/c the last time				
		seen the remote near his hand.				
	R7 stated he thoug	ht his w/c was wide enough,				
		of the w/c could be longer and				
		up further and then the w/c				
		fortable. R7 stated maybe he				
		and explained he had just fell				
	forward.					
	Review of R7's fall	incident reports revealed:				
		he floor in his room on				
		m. Incident Report indicated				
		eaching when he slipped off				
	his w/c to his knees	s. No intervention for root				
	cause was indicate					
		ne floor in his room on				
	1	n. on his knees. Incident				
	-	7 stated he was reaching for				
		out of his chair. The report big man who had difficulty				
		lo intervention for root cause				
	was indicated on th					
		d and right leg gave out and				
	lowered to the floor	to his knees on 6/27/19, per				
		Fall Incident Report received.				
		he floor in his room on 7/1/19,				
		nt Report indicated R7 stated				
		nen he slipped out of his w/c.				
		root cause was indicated on				
	the report.	he floor in his room on 0/2/40				
		he floor in his room on 9/2/19, nt Report indicated R7 stated				
		ar forward and slipped out of				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETE	(X3) DATE SURVEY COMPLETED	
00758 B. WING C	2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GARDENS AT CANNON FALLS 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE	
his w/c. No intervention for root cause was indicated on the report. -R7 was found on the floor in his room on 9/7/19, at 10:50 p.m. with his back to the front of his w/c. Incident Report indicated R7 stated he had repositioned himself and slid to the floor. No intervention for root cause was indicated on the report. -R7 was found on the floor in his room on 11/6/19, at 9:25 p.m. between his night stand and w/c. Incident Report indicated R7 stated he had been reaching for his remote and slipped and fell out of his w/c. No intervention for root cause was indicated on the report. Review of R7's progress notes dated 6/11/19, through 11/6/19, revealed no evidence of fall interventions put in place or evaluation of the effectiveness of a reacher to keep R7 from reoccurring falls. R7's nursing home physician visit note dated 10/10/19, indicated R7 was a "fall risk as he is able to get up somewhat on his own but usually ask for help." R7's care plan dated 1/2/19, indicated R7 was at risk for falls and indicated R7 would have personal items within reach. R7's careplan indicated staff would anticipate R7's needs. R7's care plan did not include an intervention for use of a reacher. DON stated on 11/8/19, at 10:09 a.m. the interdisciplinary team (IDT) had not made an intervention for each one of R7's falls as most of R7's falls were from "reaching". DON stated she thought R7 falls were actually from him falling the fall of the fall of the fall of the fall ont think there was a reacher in R7's room. DON stated she thought R7 falls were actually from him falling		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA				(3) DATE SURVEY COMPLETED	
		00759	B. WING		44/4		
		00758	D. WINO		11/1	2/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STR				
			FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 70	2 830				
	asleep in his w/c arexplained R7 was a R7 had seen a neurand lower symptom to be scheduled for RN-A, nurse manage, m. she was unavareports and to talk was possible for care as a selection of the control of the contro	and not from him reaching, and always "sleepy". DON stated rologist for right side upper as of numbness and was going additional testing. Ger stated on 11/8/19, at 1:00 ailable to go over R7's fall with DON about R7's falls. B/19, at 1:02 p.m. the IDT met gh Friday and discussed N stated R7 had just fallen was trying to come up with an antion for his falling for ed she was not aware if ted R7 for fitting of his w/c. The see managers were a planning and implementing is. DON stated staff should					
	indicated staff woul attempt to define por of the fall and identity to prevent subseque of serious conseque indicated if underly identified or correct relevant intervention the nature of the the stops or until a reast continuation. R7 leg wrap treatmer R7 was observed of in his wheelchair (whe had to wait for his wheelchair for his w	Clinical Protocol undated, d evaluate resident fall and possible cause within 24 hours ify pertinent interventions to try ent falls and to address risks ences of falling. The fall policy ng causes cannot be readily ed, staff were to try various ns, based on assessment of e fall until falling reduces or son is identified for its ent n 11/4/19, at 6:55 p.m. sitting reduces or son is identified for its					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00758	B. WING	B. WING		C 11/12/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	,		
THE GAF	THE GARDENS AT CANNON FALLS 300 NOR CANNON						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
2 830	R7 stated he asked legs at this time but she could not as shourse needed to wr wanted his legs wrabecause his physicifor his leg wound for getting up and the varieting and with a MDS indicated R7 of R7's careplan dated have compression of legs applied in the report bedtime. R7's carepart venous ulcer on his R7's physician order was to have "Complower extremities" a Lymphedema (swell R7 stated on 11/6/15 been wrapped that wound assessment R7 stated he wanter got up in the morning R7 was observed on in his w/c in his room waiting for his call lift the nurse had not you his legs should be varieting to the state of the same	In to his w/c at about 5 a.m If the night nurse to wrap his at the night nurse had told him he was too busy and the day hap his legs. R7 stated he happed when he got up his legs to be wrapped where wound would heal faster. Itated 8/1/19, indicated R7's and included a diagnosis of the ty. R7's Annual MDS indicated we staff assistance with hill activities of daily living. R7's did not reject cares. Itated 8/27/19, indicated R7 was to device applied to both lower morning and taken off at both indicated R7 had a solower right leg. It dated 11/7/19, indicated R7 was to device applied to both lower morning and taken off at both indicated R7 had a solower right leg. It dated 11/7/19, indicated R7 was to device to bilateral applied daily related to liling of fluid). It is to his legs had morning at 8 a.m. because of a completed every Wednesday and his legs wrapped when he					

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NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL PREFIX TAG COMPLET TAG CROSS-AREFERN-RED TO THE APPROPRIATE DEFICIENCY DEFICIENCY COMPLET TAG CROSS-AREFERN-RED TO THE APPROPRIATE DEFICIENCY COMPLET TAG CROSS-AREFERN-RED TO THE APPROPRIATE COMPLET TAG CROSS-AREFERN-RED TO THE APPROPRIATE COMPLET TAG CROSS-AREFERN-RED TO THE APPROPRIATE CROSS-AREFERN-TEG TO THE APPROPRIATE CROSS-AREFERN TEG TO THE APPROPRIATE CROSS-AREFERN TEG TO THE APPROPRIATE CROSS-AREFERN TEG TO THE APPROPRIATE CRAND TO THE TAG TO THE APPROPRIATE CRAND THE TAG TAG TAG TAG T	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
THE GARDENS AT CANNON FALLS 300 NORTH DOW STREET CANNON FALLS, MN \$5009 CANNON FALLS, MN \$50						С	
SUMMARY STATEMENT OF DEFICIENCIES CRACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CACH CROSS-REFERENCED TO THE APPROP			00758	B. WING		11/1	2/2019
CANNON FALLS, MN 55009 CANNON FALLS SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (PACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERRED PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE INTERPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERRED PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERRED PROVIDER'S PLAN OF COMMENT AND SHOULD BE CROSS-REFERRED PROVIDER'S PLAN OF CROSS-REFERRED PROVIDER'S PLAN OF CROSS-REFERRED PROVIDER'S PROVIDE	NAME OF I	PROVIDER OR SUPPLIER					
PRÉFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) 2 830 Continued From page 72 waiting for 10-15 minutes already. Couple minutes later registered nurse (RN)-A walked into R7's room and asked R7 what he wanted. R7 told RN-A he needed to go to the toliet. R7 was observed on 11/7/19, at 1:33 p.m. legs wrapped. R7 stated incensed practical nurse (LPN)-D had wrapped his legs this morning at 10:15 a.m. R7 stated he had wanted his legs wrapped when the night staff got him up, but the night staff would not, and stated the physician had told him the more he wears the wraps his wounds will go away. RN-A who was also nurse manager stated on 11/7/19, at 1:37 p.m. R7 could have his leg wrapped up and told him the more he wears the wraps his wounds will go away. RN-A who was also nurse manager stated on 11/7/19, at 1:37 p.m. R7 could have his leg wraps put on at 5 a.m. each day and stated she would change it on the treatment administration record so night shift would do it at 5 a.m. instead of day shift. RN-A stated she would that the time change. R7 was observed on 11/8/19, at 9:55 a.m. sitting in his w/c with his legs not wrapped. R7 stated he had saked the night nurse to do it and the day nurse to do it earlier but it had not happened. R7 stated he had been up in iw c) since 4:30 a.m. this morning and nurses had not applied leg wraps. R7 stated he had been up in w/c since 4:30 a.m. this morning and nurses had not applied leg wraps. R7 stated he had been up in w/c since 4:30 a.m. this morning and nurses had not applied leg wraps, R7 stated he physician had told him the wraps were to be on as soon as he gets up for the day. Licensed practical nurse (LPN)-E stated on 11/8/19, at 10:03 a.m. the night nurse was now supposed to wrap R7's legs at 5 a.m. instead of	THE GAI	RDENS AT CANNON I	- All G				
waiting for 10-15 minutes already. Couple minutes later registered nurse (RN)-A walked into R7's room and asked R7 what he wanted. R7 told RN-A he needed to go to the toilet. R7 was observed on 11/7/19, at 1:33 p.m. legs wrapped. R7 stated licensed practical nurse (LPN)-D had wrapped his legs this morning at 10:15 a.m. R7 stated he had wanted his legs wrapped when the night staff got him up, but the night staff would not, and stated the physician had told him the more he wears the wraps his wounds will go away. RN-A who was also nurse manager stated on 11/7/19, at 1:37 p.m. R7 could have his leg wraps put on at 5 a.m. each day and stated she would change it on the treatment administration record so night shift would do it at 5 a.m. instead of day shift. RN-A stated she would talk to R7 about the time change. R7 was observed on 11/8/19, at 9:55 a.m. sitting in his w/c with his legs not wrapped. R7 stated he had asked the night nurse to do it and the day nurse to do it earlier but it had not happened. R7 stated. "It is not good" lifting up his right pant leg to show surveyor a telpha pad with drainage on a pad on R7's lower left unwrapped leg. R7 stated he had been up in w/c since 4:30 a.m. this morning and nurses had not applied leg wraps. R7 stated his physician had told him the wraps were to be on as soon as he gets up for the day. Licensed practical nurse (LPN)-E stated on 11/8/19, at 10:03 a.m. the night nurse was now supposed to wrap R7's legs at 5 a.m. instead of	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
day nurse. LPN-E stated LPN-B (night nurse) had reported to him this morning that she had not	2 830	waiting for 10-15 m minutes later regist R7's room and aske RN-A he needed to R7 was observed o wrapped. R7 stated (LPN)-D had wrapped when the night staff would no had told him the mowounds will go awa RN-A who was also 11/7/19, at 1:37 p.m put on at 5 a.m. eachange it on the treso night shift would shift. RN-A stated stime change. R7 was observed on his w/c with his lehad asked the night nurse to do it earlies stated, "it is not good to show surveyor a pad on R7's lower lehe had been up in womorning and nurses R7 stated his physic were to be on as so Licensed practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse. LPN-E stated his physic was provided to the surveyor and and provided to wrap Eday nurse. LPN-E stated his physic were to be on as so between the surveyor and and provided practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse. LPN-E stated his physic was provided to wrap Eday nurse. LPN-E stated his physical provided practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse. LPN-E stated his physical provided practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse. LPN-E stated his physical provided practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse. LPN-E stated his physical provided practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse. LPN-E stated his physical provided practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse. LPN-E stated his physical provided practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse. LPN-E stated his physical provided practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse. LPN-E stated his physical provided practical in 11/8/19, at 10:03 a. supposed to wrap Eday nurse.	inutes already. Couple ered nurse (RN)-A walked into ed R7 what he wanted. R7 told go to the toilet. In 11/7/19, at 1:33 p.m. legs I licensed practical nurse ed his legs this morning at ed he had wanted his legs night staff got him up, but the et, and stated the physician ore he wears the wraps his y. In nurse manager stated on in. R7 could have his leg wraps in the had wanted she would atment administration record do it at 5 a.m. instead of day is the would talk to R7 about the en 11/8/19, at 9:55 a.m. sitting egs not wrapped. R7 stated he it nurse to do it and the day in but it had not happened. R7 od" lifting up his right pant leg telpha pad with drainage on a eft unwrapped leg. R7 stated w/c since 4:30 a.m. this is had not applied leg wraps. Coian had told him the wraps on as he gets up for the day. Inurse (LPN)-E stated on in the night nurse was now R7's legs at 5 a.m. instead of stated LPN-B (night nurse) had	2 830	DELIVOITY		

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	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						С	
		00758		B. WING		11/1	2/2019
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS		TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	the time change for 7 a.m. to 5 a.m. LP wrapped R7 legs to lot to do and neede RN-A, nurse manage, m. she was not an not wrapped R7's lenight nurse should the time "yesterday at 5 a.m R7 was observed on his w/c in the hal wrapped. R7 stated won't do it now." LPN-E stated on 11 not wrapped R7's legs dressing change or NA-J stated on 11/went to a medical a 8:30 a.m. and state today. NA-J stated wrapped when he leat 8:30 a.m. R7 was observed on his w/c in his root stated he had gotte appointment at noon nurse had told him legs.	R7's legs to N-E stated he day as was red to pass the ger stated on ware that the egs last night have since R" for R7's legs on 11/8/19, at lway with his d, "They (nurs after he comen the leg." 1/8/19, at 9:42 egs today and after he comen the leg. 1/2/19, at 9:42 eppointment to she had he R7 did not have fit for his med an 11/12/19, at most with no legen back from an today. R7 she was "too	e had not not time as was a e medications first. 11/8/19, at 12:47 e night nurse had t and stated the RN-A had changed is to be wrapped to 12:58 p.m. sitting legs not ses) probably 59 p.m. he had d was planning on apleted the 2 a.m. R7 had this morning at eliped him get up ave his legs edical appointment at 1:33 p.m. sitting g wraps on. R7 his medical stated the night o busy" to wrap his	2 830			
	R7's care plan date have compression legs applied in the bedtime. R7's care	devices appl morning and	ied to both lower taken off at				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00758	B. WING		1	C 1 2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STF FALLS, MN			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	COMPLETE DATE
2 830	Continued From pa	ge 74	2 830			
	venous ulcer on his	lower right leg.				
	1:02 p.m. R7 was d neurologist for right nurses should follow follow resident care should have prefere	(DON) stated on 11/8/19, at iabetic and was seeing a side numbness. DON stated w orders and staff should plans. DON stated residents ences and choices honored.				
	7/25/16, indicated, should assist reside achieving independ	mmodation of Needs dated facility's staff behaviors ent in maintaining and/or ent functioning, dignity and ommodate residents' individual aces.				
		7/25/16, indicated each allowed to choose schedules				
	11/26/18, with diagonal dementia with behat disorder, affective rundepressive disorder	dicated admission date of nosis of Alzheimer's disease, vioral disturbance, anxiety nood disorder, major r, pseudobulbar affect untary laughing or crying) and				
	Brief Interview for N had severe cognitive 1-4 days during assupervision with be eating. R15 require dressing, toileting a took an antipsychotomedication daily.	S dated 8/22/19, indicated Mental Status identified R15 re impairment. R15 wandered ressment period, needed d mobility, ambulation and d extensive assistance with and personal hygiene. R15 ric, antidepressant and diuretic				
	R15's Care Area As	ssessment dated 12/7/18,				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SI IDENTIFICATI		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00758		B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS	300 NOR	DDRESS, CITY, STH DOW STF			
(X4) ID PREFIX TAG		ATEMENT OF DEFICI Y MUST BE PRECED SC IDENTIFYING INI	IENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	indicated R15 requivanting to leave the R15 had severe counable to focus on recall what was said R15's care plan pring R15 had the potent related to dementia R15 was bothered independent with all Interventions include agitated to interven and guide away frodocument any signor others; Staff to bunit and keep R15 invade her personal needed; Redirect wat risk for doing sor distress; Monitor paracterist for doing sor distress; Monitor paracterist for doing sor distress; Monitor paracterist for during day a and the night shift of Review of R15 resivulnerable Adult (Valunerable Adul	ired a secured to a facility and he gnitive impairmed what others were d. Inted on 11/6/19 ital to be physically and poor impubly loud noises. In the source; Moning the before agitation so of R15 posing the aware of R15 from residents to a space; Cue are when R15 seems the source; Moning the aware of R15 from residents to a space; Cue are when R15 seems the source; Moning the staff of the source; Moning the staff of the source; Moning the staff of R15 posing the aware of R15 from residents the source; Cue are when R15 seems the staff of the source of R15 in the source; Cue are when R15 seems the staff of R15 in the source of R15 i	r memory loss. ent and was re saying and , indicated ally aggressive ulse control. R15 was ransfers. became on escalates, tor and danger to self activity on the chat tend to ad supervise as sconfused or ght cause g or crying nce July of ry unit was ft with two staff altercations ports revealed e July 2019, residents. e her hands nout to hit R56 ene. Report of other	2 830			
	everyone safe and -On 9/19/19, R15 a unsupervised when	nd R55 were ide					

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		7. BOLDING.		C	
	00758	B. WING			2/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GARDENS AT CANNON FAL	IS	TH DOW STR FALLS, MN			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
got within eye sight she punching each other in indicated that the secon the time of the altercated. On 10/11/19, R55 was near the exit door whe walk up behind R55 ar seen to get up from his pushing R15 before standard R15 walked up an something to R55 them with her open hand be on 11/4/19, at 1:17 p.r sitting at the table in compresent. At 1:20 p.m. ling (LPN)-F entered the composition of the will be walked down from the common are three minutes where R on 11/4/19, at 5:21 p.r sitting at a table yelling table walked over to R her about a first in your exactly what she said. There were no staff prowhere these two resides kitchen staff entered the by a direct care staff. In unsupervised for four roon 11/4/19, at 5:31 p.r walking around and storesident's hair who was no staff present in was an activity staff in	g and swearing. When LPN e found R15 and R55 in the face. The report also and staff was off the unit at tion. It is sitting in his wheelchair and rub his head. R55 was so wheelchair and starting aff could intervene. It is sitting in his wheelchair and leaned in and said in slapped him in the face affore staff could intervene. In R15 was observed common area with no staff icensed practical nurse common area just as R15 with the hall to go enter a rea was unsupervised for R15 was sitting. In R33 was observed g and R15 got up from her r33 and stated something to roose (unable to identify then returned to her table. The resent in the common area ents were. At 5:25 p.m. The common area followed the common area was minutes. In R15 was observed up	2 830			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		00758	B. WING			2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GARDENS AT CANNON FALLS			TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	common area wher common area was On 11/5/19, at 8:08 assistant (TMA)-A sand asked LPN-A ficommon area where assisted the other sareturned to common residents sitting at the were unsupervised LPN-A left the common area where unsupervised LPN-A left the common area was unsupervised for 11/6/19, at 11:1 walking down the hanother resident room the common area visually see R15 and On 11/7/19, at 7:51 with residents (including R15 unatted to the common unsupervised for significant and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room to common unsupervised for significant area and hallway. A of room t	ctivity staff entered the re R15 was located. The unsupervised for six minutes. It a.m. trained medication stepped out of a resident room or assistance. LPN-A left the re R15 was sitting and staff. At 8:16 a.m., LPN-A in area. The common area with tables and wheeling around for eight minutes. At 8:22 a.m. mon area where there were R15. At 8:30 a.m., kitchen mon area. The common area for eight minutes. It a.m. R15 was observed allway and both staff were in om. There was an activity staff a but this staff was unable to indid her whereabouts. It a.m. LPN-K left common area uding R15) present to assist room. At 7:56 a.m, LPN-K mon area having left the area we minutes. It a.m. both staff are observed to room leaving five residents rended within the common at 8:03 a.m. TMA-B came out in area that had been left at minutes. It a.m. bath staff are observed to a a.m. TMA-B came out in area that had been left at minutes.	2 830			
	stated that R15 alw and someone need					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00758	B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS 300 NOR	DDRESS, CITY, STH DOW STF			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	memory unit and the alone at times and everyone. NA-D state assistance with a rewho helped and veileft unsupervised did. During interview on indicated monitoring as R15 was very keter TMA-A stated "we cresidents when we and that was a safe. The activity director 11/6/19, at 10:20 at department did not memory unit. AD stated to assist with memory unit while sit was not part of the The assistant direct interviewed on 11/6 indicates that R15 is she lashed out unpokept an eye on R15 be always in eye sig staff need to be in a the common area the someone to come, someone monitorin other residents with R15 continued to he altercations with no was unsure if anyon altercation happened pattern.	e 200 wing so that left NA-D it was very hard to monitor ated that when she needs esident the nurse was the one rifies that the residents were uring those times. 11/5/19, at 8:53 a.m. TMA-A g R15 included watching her een on another male resident. cannot monitor all the are in getting residents up"				

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		00758		B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS	300 NOR	DRESS, CITY, STH DOW STR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICION MUST BE PRECEDON SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From paindicated R15 was on one to one super have those resource residents on that understand call for assistance and duradio call for assistance and duradio call for assistance and the common area. On 11/6/19, at 2:09 should have always view of the hall and stated there were tithe nurse went to go carried radios so the common area at all know what they will residents for aggresidents for aggresident	to be monitored rvision as the fares. DON stated into that required ing those times ance to monitor DON stated it was idents were not been one staff decommon area mes that did not ive pills but that ey can ask for hearm. licensed supported to be with mon area. p.m. NA-I state sidents when the times because do." Resident to Resident to Residents when the times because do." Resident to Resident to Residents when the times because do." Resident to Resident to Residents when the times because do." Resident to Resident to Residents when the times because do." Resident to Resident to Residents from the staff were to in the staff were to in the staff were to in the staff will identificated at a staff will identificated at the staff will identificated and the staff will identificated abuse abuse abuse and the staff will identificated abuse	cility did not there were two staff staff had to residents in as her left alone in cated there within eyes ideally. RN-A happen as was why staff elp. ocial worker th R15 when d someone ey were in the "you never sident re to monitor priate y and stitute residents to he Abuse ed staff were in abuse. The fy occurrences implement	2 830			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLEX (X3) DATE SU COMPLEX (X4) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLEX (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DATE SU COMPLEX (X6) DATE SU COMPLEX (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) DATE SU COMPLEX (X7) DATE SU COMPLEX (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) DATE SU COMPLEX (X7) DATE S					
			A. BOILDING.		,	
		00758	B. WING			2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 80	2 830			
	was current tobacc cognition. R43's and diagnoses included disease, peripheral diabetes mellitus. Findicated R43 requiversight with active R43's Smoking Rerestand diabetes mellitus. R43's Smoking Rerestand diabetes mellitus. R43's Smoking Rerestand diabetes moking Rerestand diabetes moking related incomplete smoke. The review smoking related incomplete smoking apron" and smoking apron" and smoking apron" and smoking. The review policy related to smoking materials evidence regarding materials. R43's Care Plan rerestand diabetes and hazards, smoked and hazards, smoked diabetes and diabetes and diabetes and diabetes and diabetes	view dated 10/15/19, identified tly smoke, however intended to indicated R43 had a history of cidents which included burning ng, burning furniture, dropping indicated R43 "must wear dutilize cigarette holder when aw indicated staff reviewed the noking times and storage of with R43, however lacked grafe storage of smoking wised on 10/23/19, indicated a smoker and directed staff to any smoking apron every time instruct about smoking risks sing cessation aids, instruct				
	concerns, notified of was suspected R43 policy, observed clocigarette burns, R4 using a cigarette hothis lap. R43 was all	noking: locations, times, safety charge nurse immediately if it 3 had violated facility smoking othing and skin for signs of 3 could smoke unsupervised, older and smoking apron on ole to light his own cigarette, ing supplies and roller at				
		e (PN) were reviewed from 0/29/19, and revealed the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00758	B. WING		11/1	; 2/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
THE GARDENS AT CANNON	FALLS	H DOW STR			
OUR MADY OT		FALLS, MN		011	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830 Continued From pa	ige 81	2 830			
following: -On 8/30/19, the PN Nursing (DON) obs R43's inner index fi was identified as a middle finger to hol dated 8/30/19, indic mark on his hand th R43 was deemed to supervision on the R43 did not wish to smoke off of the pr -On 9/10/19, the PN (SW) talked with Re smoke and offered fingers and wearing burning clothing; -On 9/11/19, the PN to have been safe to protective devices of apron, R43 had agreed devices; -On 9/19/19, the PN to have been outsic special gloves or si agreement" R43 st educated to wear th for safety reasons; -On 9/20/19, the PN smoking privileges devices for smoking -On 10/29/19, the PN smoking ring for sa smoking. R43 was observed the designated smobuilding, R43 remo	N indicated the Director of served two open areas on onger and middle finger. R43 smoker and used "index and digarette." A subsequent PN cated R43 was noted with burn that was related to smoking, unsafe to smoke without property. The PN indicated a stop smoking and agreed to operty; N indicated Social Worker 43 about not being safe to a holder to protect R43's gran apron to protect R43 from N indicated R43 was assessed to smoke with the following cigarette holder and smoking reed to use both of the N indicated R43 was observed de smoking "with out his moking apron per facility ated "I just got back". R43 was ne smoking gloves and apron N indicated R43 lost his due to not wearing his safety	2 030			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 20.2210			c
		00758	B. WING		11/	12/2019
NAME OF	PROVIDER OR SUPPLIER		ET ADDRESS, CITY,			
THE GARDENS AT CANNON FALLS			IORTH DOW ST NON FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 82	2 830			
	wheelchair while sn ash on the ground I was ashing his ciga drop white ashes or	ring. R43 was seated in his noking and was observed t between his legs. While R4 arette R43 was observed to n to his pants. R43 did not as on his clothes, hand and	3			
	stated that "the staf any instruction abou stated he did not ha unable to locate his indicated it was ok and lighter unlock of time of the interview	ed on 11/6/19, at 8:50 a.m. If does not tell me or give mut going out to smoke." R43 ave cigarette ring or holder s smoking apron. R43 for him to leave his cigarette in his bedside table. At the WR43 was observed to have bacco and lighter unlocked able.	ne 3 and e			
	and stated R43 sm	ved on 11/6/19, at 8:41 a.m oked independently and NA y supplies R43 needs to				
	and stated R43 new went to smoke. LPN supposed to go out cigarette holder. LP	ewed on 11/6/19, at 11:08 a ver notified anyone when he N-D indicated R43 was with a smoking apron and PN-D stated when she would smoking apron, she would ded one.				
	and stated that it wand residents to foll explained R43's sm to his cigarette was fit. DON confirmed cigarette holder in h	red on 11/08/19, at 1:14 p.n as her expectation for staff low the care plan. DON noking ring was on order dust difficult to find a right ring R43 should have had a nis room available for use. ad been non-complaint	ıe			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00758	B. WING		11/1:	; 2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALLS	TH DOW STR			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	FALLS, MN	PROVIDER'S PLAN OF CORRECTI	ON	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 83	2 830			
		s smoking apron and cigarette d staff would spot check to oked safely.				
	11/8/19, indicated a not comply with rule be asked to restrict privileges. Policy in would be completed and "Any smoking-and concerns (for emonitoring fire retain noted on the care pfor the resident shaLighters MUST be when coming in from R25's MDS dated 9 that included depression of the complete shadows.	g Policy-Residents revised any residents or visitor who did as regarding smoking would and/ or forfeit their smoking dicated smoking assessment d before resident could smoke related privileges, restrictions, example, need for close rdant smoking aprons) shall be plan, and all personnel caring all be alerted to these issues the returned to nurse's station m smoking." 1/11/19, identified diagnoses assion and end stage liver indicated R25 was				
	R25 was interviewed and stated he smoke per day. R25 indicate had to stay in a speaway from the entra	ed on 11/6/19, at 11:49 a.m. ked a half pack of cigarettes ted the rules were smokers ecific area outside which was ance. R25 stated he had his er in a shelf in his room.				
	a.m. and stated he supplies kept in his also kept his lighter lighter were visible The lighter was not brought out lighter to drawer of a bedside	ed again on 11/7/19, at 11:29 rolled his own cigarettes with room. R25 indicated that he in his room. The supplies and on a shelf under a refrigerator. ed to be a refillable type. R25 fluid kept in an unlocked e table. R25 stated he had not only use disposable lighters.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00758	B. WING			C 12/2019
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		12/2013
THE GAI	RDENS AT CANNON I	300 NOR	TH DOW STF FALLS, MN	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
2 830	and verified that rescigarettes and lighteneed to keep the sustated the policy was cigarette supplies from their rooms because to the ombudsman were property of the R25's care plan dat was a smoker and resident will not sufpractices through the resident about smooking cess Instruct resident about smoking: locations, Monitor oral hygiene immediately if it is sviolated facility smooth and skin for signs of can smoke unsuper (light own cigarette). R25 signed a smoke policy dated 9/20/19 be in a locked box as smoking products wand the residents working products wand the residents working products wand the residents working products of the property of the state of the supplier social Worker (LSW 11/8/19, at 8:42 a.m. current smoking pobecause cigarettes personal property of ombudsman. LSW	wed on 11/7/19, at 11:29 a.m. sidents were allowed to keep ers in their rooms and did not upplies locked up. LPN-E as changed from requiring rom being locked at the llowing residents to keep in e there was a complaint made who indicated the materials	2 830			

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STATEMENT OF DEFICIENCIES (X1)

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00758	B. WING		11/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CAR	RDENS AT CANNON I	300 NORT	H DOW STR	REET		
THE GAR	RDENS AT CANNON I	CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 85	2 830			
	forced to wear an a to have a smoking a be unsafe, the privi residents could not were determined to aware that R25 kep LSW-A stated she indicated the lighter	pron. Residents were required assessment and if deemed to lege was taken away. The have a cigarette until they be safe. LSW-A was not ot lighter fluid in his room. did not do room searches, but refluid would be taken away.				
	The administrator, designee could reviprocedures regarding assessment of resignassessment and sure of Nursing) or design procedures for resign for staff assistance condition. Facility states policies and procedures of these policies and procedures of the procedure of the procedure of the procedures of the procedure of the procedures of the procedure	dent transfers, smoking apervision. The DON (Director gnee could review policies and dent preference for timeframe with treatments and change of taff could be educated on procedures. The administrator, could develop a monitoring ngoing compliance.				
	(21) days.	R CORRECTION: Twenty One				
2 890	MN Rule 4658.0529 Motion	5 Subp. 2 A Rehab - Range of	2 890			12/29/19
	that is directed towa through positioning implemented and n comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			,
		00758	B. WING			<i>2</i> /2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	LALIG	TH DOW STI FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	without a limited rai experience reduction the resident's clinic that a reduction in unavoidable; and This MN Requirements: Based on observation review, the facility for motion exercises for reviewed for limited. Findings include: R4 was observed on the Broda chair in fingers curled in. R4's Quarterly MDS R4's cognition was dependent on staff personal hygiene a	who enters the nursing home nge of motion does not on in range of motion unless all condition demonstrates range of motion is ent is not met as evidenced ion, interview and document failed to provide range of or 1 of 2 residents (R4) drange of motion. on 11/4/19, at 6:29 p.m. sitting in her room with her left hand. Significantly assistance for dressing and ind did not reject cares. R4's	2 890	Corrected		
	limitation in ROM w extremities. Finger identified on the qu	cated R4 had functional vith both upper and lower contractures were not arterly assessment.				
	1/11/19, indicated F shoulder arthritis ar not indicate location	sessment (CAA) dated R4 had limited ROM, bilateral nd contracture. R4's CAA did n of the contracture and did exercises were to be				
	(MDS) dated 7/26/1	ange Minimum Data Set 19, indicated R4's cognition R4 had diagnoses of Arthritis,				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUIL DING. COMP	(X3) DATE SURVEY COMPLETED	
A. BUILDING:		
00758 B. WING 11/1	; 2/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
THE GARDENS AT CANNON FALLS 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 890 Continued From page 87 hemiplegia or hemiparesis and was hospice care. R4's Significant Change (SC) MDS indicated R4 needed extensive staff assistance with all activities of daily living (ADLs) and did not reject cares. R4's MDS indicated R4 had functional limitation in range of motion (ROM) with both upper and lower extremities. Finger contractures were not identified on the assessment. R4's CAA dated 7/26/19, indicated hospice care started on 7/19/19. R4's CAA indicated R4 had limited range of motion and needed staff assistance related to left side hemiplegia, rheumatoid arthritis, weakness and contracture. R4's CAA did not indicate location of the contracture and did not indicate ROM exercises were to be performed. R4's care plan dated 11/5/19, indicated goal was to prevent contractures from forming. R4's care plan indicated R4 would be monitored, documented and reported as needed for forming or worsening contractures. R4's left fingers contractures were not identified on the care plan nor interventions of ROM exercises included on R4's care plan. R4's Occupational Therapy (OT) Treatment Encounter Note dated 4/8/19, indicated R4 was referred to OT due to decline in ability to perform functional activities without physical assistance, joint stability, postural alignment, pain and ROM. R4's OT note dated 4/9/19, indicated R4's left hand was in a fist and would be placed with possible palm protector or splint at night/day. The OT note did not indicate ROM exercises for the fingers would be performed. R4 was observed on 11/7/19, at 1:25 p.m. laying on bed with left fingers curled in. R4 stated she		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY
ANDILAN	OF CONTRECTION	IDENTIFICATION NOWIDER.	A. BUILDING:			LLTLD
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		00758	B. WING		1	2/2019
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THE GAI	RDENS AT CANNON I	FALLS	TH DOW STR			
	Г		FALLS, MN			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		DATE
		,		DEFICIENCY)		
2 890	Continued From pa	go 99	2 890			
2 030	Continued From pa	ge oo	2 090			
		n our her fingers and was				
	concerned about it.	R4 stated she did not want				
		et any worse. R4 tried to open				
		t could not stretch out her				
	fingers all the way	open.				
		(I DNI) D. (()				
		nurse (LPN)-D stated on				
		n. she had not assessed R4's				
	left fingers for contr	actures.				
	Nureing accietant (I	NA)-J stated on 11/7/19, at				
		not perform ROM or exercises				
		NA-J pulled out her NA care				
		d ROM/exercises was not				
	identified on the car					
		re sheet for R4.				
	Registered nurse (F	RN)-A, who was also nurse				
		11/7/19, at 1:42 p.m. R4 had				
	a history of stroke a	and frozen left shoulder and				
		n because of pain and did not				
	, •	RN-A stated R4 did not receive				
		RN-A stated ROM could be				
		omfort but was presently not				
		. RN-A called on the telephone				
		ector (TD) on speaker and				
		en seen by therapy. TD stated				
		with R4 in the spring for				
		e upper part of body for pain				
		tated therapy had not				
		er contractures for R4 and R4				
		oth hands. TD stated therapy				
		provide three visits she				
		d she would e-mail hospice for				
		by therapy for ROM for her				
	left fingers contract					
	R4 was observed o	n 11/8/19, at 9:52 a.m. sitting				
		n her room. R4 stated a				
	couple of staff had	come and talked to her about				
		s. R4 stated she did not know				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ODATE SURVEY COMPLETED	
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON F	FALLS	TH DOW STF I FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 89	2 890			
	help with the fingers she was not interes only wanted ROM e Nursing assistant (No. 19:43 a.m. that R4 le	NA)-J stated on 11/12/19, at ets her wash her hands. NA-J				
	the left hand, but no	en up some of her fingers on ot all the way open.				
	a.m. she was here her fingers on her le could open up her f stated she had not) stated on 11/8/19, at 11:32 to see R4. HN stated R4 kept eft hand curled and stated R4 ingers with some pain. HN noticed R4 could not open her ay and would assess and ctures and ROM.				
	identified contracture stated R4 could onle fingers and was going	/19, at 9:31 a.m. she had now res for R4's left fingers. HN y partially open up her left ing to have therapy evaluate M and splint with some wear				
	had discussed with Occupational Thera hand contractures t	dated 11/8/19, indicated HN RN-A about ordering an apy evaluation for R4's left o see what could be done to stiffness and order was				
		(DON) stated on 11/8/19, at not aware of R4's left fingers				
		12/19, at 11:48 a.m. R4 should d for contractures before				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00758	B. WING			C 1 2/2019
		00758			1 11/1	12/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	EVILE	TH DOW STF □ FALLS, MN			
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 90	2 890			
	undated, indicated receive Rehabilitati developed and coo care plan. The policassisted with exerc	bilitative Nursing Care each resident admitted would we nursing care and would be rdinated through the resident's by indicated residents would be ises between visits of the d be assisted with their routine ercises.				
	The facility could wand therapy departion programming for remotion services or facility could develo	THOD OF CORRECTION: ork with the QA Committee ment to identify and develop sidents in need of range of those at risk for decline. The p systems to audit range of completion and report to the				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			12/29/19
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
		ho has pressure sores y treatment and services to				

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	PROVIDER OR SUPPLIER	FALLS 300 NOR	DDRESS, CITY, TH DOW ST			
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2 900	Continued From pa promote healing, pr new sores from dev	event infection, and prevent	2 900			
	by: Based on observation review, the facility formonitoring, compressimplementation of inhealing of a facility	on, interview and document ailed to ensure ongoing thensive assessment, and interventions to promote acquired right and left stump 1 of 2 residents (R43) ure ulcers.		Corrected		
	10/3/19, identified If diagnoses included disease, peripheral diabetes mellitus. Thad one unstageable coverage of wound pressure ulcer. The risk of developing processure ulcer care medications other to	ed nutrition or hydration, e, applications of ointments/ han to feet. The MDS further ired supervision and/or				
	Assessment (WWA 10/16/19, through 1 following: -The WWA dated 1 pressure area to thwhich was noted as WWA identify "no"	tes (PN) and Weekly Wound A) were reviewed from 1/6/19, and revealed the 0/16/19, indicated R43 had e front of right "lower leg" s a new area, however R43 R43's care plan was not d. A subsequent WWA dated				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		00750	B. WING		(
		00758	D. WING		11/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			H DOW STR			
THE GAR	RDENS AT CANNON F	FALLS				
		CANNON	FALLS, MN	55009		
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				BEI IOIEITOT/		
2 900	Continued From pa	ae 92	2 900			
		R43 had a pressure area to				
	the front of left "low	er leg" wound was previously				
	healed and re-injure	ed related to artificial legs use,				
	however R43 WWA	identify "no" R43's care plan				
		r updated. An additional WWA				
		icated R43 had a second				
		e front of the left "lower leg"				
		a new area, however R43				
		R43's care plan was not				
	reviewed or updated. Additionally, WWA dated 10/16/19, indicated R43 had a pressure area					
	,	•				
		nee which had noted				
		ermore, WWA dated				
		R43 had a second pressure				
		left knee which had noted				
	improvement;					
	-The PN dated 10/2	23/19, identified R43 was				
	approached before	leaving for dialysis to				
	complete wound as	sessment of R43's lower				
	stumps and indicate	ed R43 had both of his artificial				
	legs on, and would	not take them off for an				
	assessment;					
		8/19, indicated R43 was				
		to dialysis, floor nurse				
		ed Nurse (RN)-A to "observe"				
		R43 did not have his artificial				
		tumps observed. Pressure				
		ront leg intact, blanchable				
		ind left knee covered with				
		ainage, erythema or				
		l open area to top of left leg				
		rep applied, adhesive foam				
		applied to right lower leg and				
		lowever, the PN lack				
		urement and evaluation of				
	current intervention	*				
		30/19, indicated R43 was				
	seated in the wheel	chair with artificial legs on and				
		r wound observation The PN				

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indicated R43 declined, staff re-approached R43

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/1	2/2019	
	NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS CANNO CANNO						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 900	prior to leaving for again; -The PN dated 10/3 care needed to be of Thursday, however outside every time is [treatment];" -The PN dated on 1 observation of both had both of his artift to take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and don't not a take them off. The are fine and discussed with R43 treatment and asset the asset of the doctor was on Wednesday, depth where possible status of wound perhealing progress, redeclines to the doctor was on Wednesday, and cover with adher R43 care plan lack regarding wound as addition, R43 care plan lack regarding wound as addition.	dialysis and R43 declined dialysis and R43 declined done on every Monday and the PN indicated R43 "was staff wanted to do Tx 1/6/19, indicated R43 refused of the stumps, due to R43 icial legs on and did not want the PN indicated R43 said "they eed anything anymore." rd was further reviewed and weekly wound monitoring to ents, evaluations of consistent treatments to the wound. In addition, R43 a evidence of risk and benefit or regarding refusal of wound essment. re initiated on 9/27/19, at risk for skin breakdown and minister treatments as ordered	2 900				

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		00758	B. WING			C 12/2019
	PROVIDER OR SUPPLIER RDENS AT CANNON I	FALLS 300 NOR	DDRESS, CITY, S TH DOW STR I FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	R43's Pressure Ulc (CAA) dated 10/17/ unstageable pressure with medical recommodirected staff to assocks, insulin manarificial legs. R43 was interviewed and stated staff usure however indicated the wound recently. R4 wound care, however completed prior to provide the day. RN-A was interviewed and stated R43 words stated R43 words supposed to be dornefused. RN-A stated and often refused wound assessment. RN-A was observed while doing dressing assessed the wound measured 0.5 cention described as "super that R43 right stum dressing on at all time wound was not cover change. RN-A asseleft knee which meadescribed "no depthy very light pink." RN-additional pressure.	ers Care Area Assessment 19, identified R43 had an are ulcers and bilateral lower tion and was non-compliance mendations. The CAA sist with placement of shrinker agement and ambulation with and on 11/07/19, at 8:31 a.m. ally put the dressing on, the staff had not observed his 3 stated he would not refuse ter preferred wound care was butting both artificial legs on ared on 11/07/19, at 8:41 a.m. and assessment was the daily however R43 often the dR43 was "very resistance to take artificial legs off for ared on 11/07/19, at 9:11 a.m. and g change for R43. RN-A d on R43's right stump which meters (cm) by 1.2 cm and arficial, dry." RN-A confirmed ap was supposed to have had a ames, however, verified R43 ared prior to the dressing assed the wound behind R43 asured 1.5 cm by 1.5 cm and an, very superficial, resurface and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing assured 1.5 cm by 1.5 cm and an of the dressing	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00758	B. WING		11/1	<i>2</i> /2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE GA	RDENS AT CANNON	FALLS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	artificial legs on and dialysis day and tolk wound assessment stated to RN-A "you ready to leave for danswered, "I know The director of nurs 11/8/19, at 1:00 p.m practitioner who warounded weekly wit wound assessment expected a dressin and if it wasn't there staff as soon as powas always the first wound assessment refuse. The facility Pressur policy undated, indiMonitoring: a. Stainspections (with danotified to inspect to identified. c. Nurses at least weekly to identified. c. Nurses at least weekly to identified procedure 4. Once completed proceed or Weekly Skin Interwhether this is a neresident) and comp 6. Proceed to caindividualized for the risk factorsDocurefused the treatment the resident's responsible of refusing the accepting and avail	d off for wound assessment on d RN-A he preferred the to be done before. R43 a always" wait until "I" was ialysis with my legs on. RN-A	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PLUI DING.		SURVEY LETED				
7.110 1 27.11	or correction.	BERTH TOX THOMBER.	A. BUILDING:			
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON		TH DOW STR			
			FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 96	2 900			
	SUGGESTED MET The director of nurs all residents at risk they are receiving t treatment/services from developing an pressure ulcers. To designee, could con delivery of care; to services are impler pressure ulcer deve	rhod of correction: sing or designee, could review for pressure ulcers to assure he necessary to prevent pressure ulcers d to promote healing of he director of nursing or nduct random audits of the ensure appropriate care and mented; to reduce the risk for				
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			12/29/19
	comprehensive reshome must ensure A. a resident is treatments and senabilities in activities deterioration is a not the resident's condipart, activities of daresident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and (5) use speech	s given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this aily living includes the ss, and groom; d ambulate;				
	This MN Requireme	ent is not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATI COM			SURVEY LETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON F	EALLS	TH DOW STI	· 		
040.15	CUMMADVCTA		FALLS, MN		ON	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 97	2 915			
	review, the facility fa assess and ensure services were deve incontinence for 1 c	on, interview and document ailed to comprehensively the necessary cares and loped regarding bladder of 1 resident (R35) who was me of her ADL activities.		Corrected		
	her call light on. At (NA)-C entered R35 to be lying in bed wi from R35's bed. R3 bathroom as NA-C indicated R35 was NA-C indicated R35 urine and needed to R35 to turn onto he wet with urine from the middle of the bath (NA)-C indicated R35 to turn onto he wet with urine from the middle of the bath (NA)-C indicated R35 to turn onto he wet with urine from the middle of the bath (NA)-C indicated R35 to turn onto he wet with urine from the middle of the bath (NA)-C indicated R35 was not considered.	on 11/7/19, at 7:10 a.m. with 7:19 a.m. nursing assistant 5's room. R35 was observed ith a strong urine odor coming 5 requested to go to the removed R35's blanket NA-C lying in a urine soaked bed. 5's "entire bed was "wet" from 5 be changed. NA-C assisted r side and indicated R35 was the middle of the thighs up to ack. NA-C indicated the urine dding around the edges and ld and wet.				
	stated she had asked around midnight, he whom answered he off and did not resp room. R35 stated standicated it "only ha would not assist R3" NA-C was interview and stated there we when residents would not assist would not assist R3"	ed on 11/7/19, at 7:35 a.m. and ed to go to the bathroom owever indicated the staff or call light turned her call light ond and walked out of the he went back to sleep and ppens sometimes" when staff to the bathroom. Wed on 11/7/19, at 7:40 a.m. ere certain days of the week all d be found in bed that were atted wet beds was not				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00758		B. WING			C 12/2019
	NAME OF PROVIDER OR SUPPLIER THE GARDENS AT CANNON FALLS CANNOI						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 915	R35 was observed told the administrat had an accident du "she was soaking wheen on the schedudon't lay in bed soa R35's annual Minim 9/26/19, indicated Fimpairment and dia indicated R35 required ADL and did not had MDS further indicated incontinent or urine R35's care plan rewhad a self-care perfect staff to assist for toof bladder, change R35's care plan rewhad occasional bower lated to need for stasks and use of michange as needed each incontinent epand symptoms of urindicated "care plan with strategies to mable." NA-A was interview and stated she four "entire bed is wet" for the strategies wet."	on 11/7/19, at 8:3 ion during breakfaring the night. R3: vet" and staff shoule to help people king wet." num Data Set (MER35 had moderate gnoses which incodetes mellitus. The red extensive assive a toileting proged R35 was occar and bowel. ised 10/2/19, identified and bladder in staff assistance we dications and directly when soiled, periodical per	ast that she 5 indicated ald have "so that they "S) dated a cognitive luded manic he MDS sistance with gram. The asionally and directed I incontinent as needed. Incontinent as needed staff to care with for for signs on. The signs on. The signs of the signs of the signs of the signs of the signs on. The signs of t	2 915			
	told the NA "last nig bathroom due to co	ht" to assist R35	to the				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
						,
		00758	B. WING			<i>2</i> /2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CAL	DENC AT CANNON I	300 NORT	TH DOW STR	REET		
THE GAI	RDENS AT CANNON I	CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 915	Continued From page 99		2 915			
	however was unsur	e what happened.				
	stated she was wet not like to be wet. F	ed on 11/8/19, at 7:45 a.m. and and cold that morning and did a35 indicated when requested, aff had assisted her to the				
	11/8/19, at 12:01 p. expectation to compassessment and dewhen the resident r DON further stated	sing (DON) was interviewed on m. and stated it was her plete a bladder three day evelop the care plan based on needed to be toileted. The it was her expectation for staff to the bathroom when				
	Assessment and M 8/8/16, indicated as the nursing staff wo related to urinary in relevant information wet bed or clothing would provide sche voiding or other interincontinence. The princontinence care sindividualized at nig and skin integrity ar	ht in order to maintain comfort nd minimize sleep disruption.				
	The director of nurs review, revise polici assessment and to could be educated procedures. DON of monitoring system is	HOD OF CORRECTION: sing (DON) or designee could les and procedures bladder lileting care plan. Facility staff on these policies and or designee could develop a to ensure ongoing compliance. R CORRECTION: Twenty One				

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STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00750	B. WING		44/4	
		00758			11/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	-ALLS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 100	2 915			
	(21) days.					
	(21) days.					
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			12/29/19
	comprehensive res home must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 of 5 residents (R44) and weekly shower assistance for 1 of 5 residents (R43) who needed assistance with activities of daily living (ADLs). In addition, the facility failed to provide shaving assistance for 2 of 5 residents (R29, R44) who needed assistance with grooming.			Corrected		
	Findings include:					
	his call light on. At a had been on the be minutes" and needed bed pan as he had At 8:05 a.m. nursing observed to answer R44's room R44 tol "waiting more than to have had a bower pericares and assist R44 also said to NA	on 11/8/19, at 7:40 a.m. with 7:59 a.m. R44 indicated he d pan waiting for "30 to 45 ed assistance to get off of the "been done for a long time." g assistant (NA)-A was R44's call light when entering d to NA-A he had been I should." R44 was observed el movement NA-A provided et de R44 off of the bed pan. A-A that he had been waiting A-A replied, "we are working				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00758	B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS 300 NO	ADDRESS, CITY, S RTH DOW STR ON FALLS, MN	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 920	as fast as the two of R44's quarterly Min 10/7/19, identified In diagnoses which in depression. The quired extensive frequent incontinent program. R44's care plan reversed had an ADL seand directed staff to fataff for the use of movements. R44 was interviewed stated staff when sea long time for assistant activating his call light NA-A was interviewed and confirmed R44 minutes on the bed "really far behind" of the director of nurse 11/8/19, at 1:06 p.n. staff to respond as	of us can." Imum Data Set (MDS) dated R44 had intact cognition and cluded dementia and manic larterly MDS indicated R44 assist with toileting and was to bowel without a toileting rised on 10/22/19, indicated elf-care performance deficit or provide extensive assistance of the bed pan for bowel and the bed pan for bowel as a stance from staff after ght. Ived on 11/8/19, at 8:15 a.m. are taff would call in he would was stance from staff after ght. Ived on 11/8/19, at 8:20 a.m. and was waiting at least 30 and pan. NA-A stated they were getting residents up for the date in and stated she expected promptly as they were able.	nd it y.			
	had intact cognition included anemia, e peripheral vascular	dated 10/3/19, identified R43 and diagnoses which nd stage renal disease, disease and diabetes al MDS further indicated R43				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00758	B. WING			<i>2</i> /2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GARDENS AT CANNON FALLS			TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ige 102	2 920			
	required supervisio	n and/or oversight with ADLs.				
	10/17/19, identified	rea Assessment dated R43 needed staff assistance cted staff to meet R43's needs				
	required assistance staff to provide one showers. The care	vised 10/23/19, identified R43 with showering and directed staff assist with weekly plan indicated R43 would rs when tired and/ or when tle staff available.				
	telephone on 11/5/R43 had not had a FM-B stated a weed please" ensure R43 a male would show waited an hour and shower and stated staff and asked who FM-B stated the staff R43 needed a show stated when she cathree days later R4FM-B stated she explast care conference	M)-B was interviewed via 19, at 10:33 a.m. and stated shower in over two weeks. It ago she "asked the nurse 3 was showered and requested for R43. FM-B indicated she nobody came to offer R43 a she then approached a male en R43 would be showered. In affindicated he was unaware wer and walked away. FM-B ame back to visit R43 two to 3 "still" had not had a shower. Repressed a concern at R43's the regarding showers not staff indicated they would look				
	through 11/7/19, ar every Thursday at 8 and the documenta -On 9/15/19, the re bathing;	ort was reviewed 9/15/19, and directed staff to shower R43 3:00 p.m. male caregiver only ation revealed the following: port indicated R43 refused				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00758	B. WING			C 1 2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
THE GA	RDENS AT CANNON I	FALLS	RTH DOW STI N FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 920	-On 9/29/19, the repapplicable;" -On 10/13/19, the repapplicable;" -On 10/27/19, the repapplicable;" -On 10/31/19, the repapplicable;" -On 11/7/19, (after sindicated extensive) R43 was interviewed stated he "wants as have approximately with brown dirt undowith food stains on malodorous. R43 sin over two weeks a staff would come based on the state of the repapple o	port indicated bathing "Not eport indicated bathing "Not eport indicated independent eport indicated bathing "Not survey began), the report assist with bathing. ed on 11/6/19, at 8:32 a.m. an shower." R43 was observed to quarter inch long finger nails erneath the nail, dirty clothing them, and R43 was tated he had not had a shower and when he had requested in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS 300 NOR	DDRESS, CITY, S TH DOW STF I FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 920	Continued From pa A facility policy rega but not provided.	ge 104 arding bathing was requested,	2 920			
	severe cognitive im extensive assistant perform personal h included Alzheimer behaviors, weaknes	rterly MDS identified R29 had pairment. R29 required se of one staff to dress and ygiene. R29's diagnoses is disease, dementia with ss, degenerative joint disease, led movement), and history of				
	cognitive loss, limite weakness. R29 was the required extens dress and perform unable to communianticipate and mee aggressive behavior diagnosis of dehydrand assist R29 with intake, and provide R2 was at risk for a	ntified R29 had dementia with ed physical mobility, and as unable to provide self-care. ive assistance of 1 staff to personal hygiene. R29 was cate needs. Staff were to t R29's needs. R29 had r with cares. R29 had a recent ration. Staff were to supervise meals, encourage fluid a nosey cup for fluid intake. spiration and had problems ing while eating and drinking. straws.				
	R29 required exten perform personal hywith supervision. R2 to ensure staff coulduring meals. Staff the day and use a r	rent NA care sheet included sive assistance of two staff to ygiene. R29 was to eat only 29 ate in the small dining room d observe him at all times were to offer fluids throughout nosey cup for liquids.				
	Observation on 11/	4/19. of R29 at 10:37 a.m.				

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00758	B. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STR FALLS, MN			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
2 920	Continued From pa	ge 105	2 920			
	identified R29 appe under his fingernail	ared unshaven, and debris s.				
	Observation on 11/07/19, at 7:32 a.m. R29 sat in the hallway by the nurse desk. R29's face was patchy with long facial hair under his nose on lower lip chin.					
	Observation on 11/06/19, at 11:56 a.m. R29 was lying on the right side in bed with oxygen on. R29 remained unshaven with white facial hair visible on his on upper and lower lip and left side of his face.					
	Observation on 11/07/19 at 1:15 p.m. R29 was in his wheelchair at the nurse station. R29 remained unshaven. Licensed practical nurse (LPN)-E handed R29 a 4 ounce glass of supplement with a straw and cued him to drink it. R42 stated to drink the supplement. LPN-E turned toward the cart and resumed passing medications. LPN-E pushed the cart away from the direction where R29 sat and entered and exited other rooms without providing R29 supervision while drinking the supplement. R29 continued to drink the supplement through the straw until gone.					
	stated he was unaw drink with a straw. not looked at R29's R29 a straw to drint checked R20's elec	verified it did not indicated				
	identified she was a unshaven face. Sta	19, at 2:54 p.m. with DON aware of R29's unkempt ff reported they attempted to azor blades were dull. Two				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′		` '	LETED
		00758	B. WING			<i>,</i> 2/2019
						2/2010
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE GA	RDENS AT CANNON I	FALLS	TH DOW STF FALLS, MN			
040.15	CUMMA DV CTA		-			0.(5)
(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 CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE	(X5) COMPLETE DATE
2 920	O Continued From page 106		2 920			
	weeks ago, DON copurchase new razonew, and unable to purchase new bladehad no razor bladesmeantime. DON stacups for R29 and pand fluid intake. The DON expected staff Interview on 11/08/therapist (ST)-A verand supervision to staff to not use straswallowing well follocondition and was a where fluids had the and lungs. The only aspiration was by p study. R29 was to uhad been canceled hospice. ST-A was was appropriate with	ontacted R29's guardian to r blades. R29's guardian was access R29's money to es until recently. The facility is for R29 to use in the ated staff were to use nosey rovide supervision with meals e care plan stated no straws. If to follow R29's care plan. 19, at 11:49 a.m. speech rified R29 required assistance eat and drink. ST-A instructed with the because R29 was not owing a recent change in at risk for silent aspiration e potential to enter his airway way to diagnose silent erforming a video swallow undergo testing, however that due to R29's admission to a unable to verify if straw use thout a video swallow study. It is to the sundergo testing to the sundergo testing to the sundergo to the s				
	cognition was intact depression, but felt several days per we and no behaviors. F included extensive transfer. R42 requir	rterly MDS identified his t. R42 had minimal signs of tired and had little energy eek. R42 had hallucinations R42's functional status needs assistance of 2 staff to red extensive assistance of 1 y, locomotion on and off the anal hygiene.				
		interview with R42 on m. identified R42 was lying in				

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	it of Department of The		(VO) MULTIPL	E CONOTRUCTION	(VO) DATE	OLIDVEY.
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	LETED
,	0. 0020		A. BUILDING:			
					c)
		00758	B. WING		11/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TO WILL OF T	TO VIDER OR GOLF EIER		H DOW STF	•		
THE GAR	RDENS AT CANNON I	FALLS	FALLS, MN			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 920	Continued From pa	ge 107	2 920			
		s at floor level. R42's bed and				
		s on it. He was wearing				
		al hair was ½ inch long, and				
		R42 was not growing a beard				
		shave because the electric				
		tly purchased was missing.				
		th how they do things around [staff] don't listen". R42				
	reported his concerns and notified nurse aids, nurses, and DON about his missing razor and					
	never heard back from anyone. R42 gave up					
		equired assistance to shave,				
		room and perform daily care.				
		assistance with ambulation in				
		e tired easily. On several				
		ed for assistance to get back				
		old R42 could push himself				
		sed to help him back to his				
		lly waited for over one-half				
	hour for assistance	when he activated his call				
	light to get help.					
		11/04/19, at 6:41 p.m. through				
	·	m. identified R42 continued to				
	be unshaven.					
	Observation and int	tondow on 11/07/40 at 12:42				
		terview on 11/07/19, at 12:42				
		taff periodically check R42's				
		ter to make sure it was on. ne needed oxygen at all times,				
		wearing it. NA-C had not				
		room after lunch, and was				
		staff assisted him to his room.				
		dal himself in the hallways				
		m, and was unsure if he				
		to and from the dining room.				
	. squired noip to got	to and norm the diffing room.				
	Interview on 11/07/	19, at 2:44 p.m. with DON				
		sked staff to shave R42 for				

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the past 2 days. DON was aware R42 reported

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		00758	B. WING		11/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1	
THE GAF	RDENS AT CANNON I	-ALLS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	grievance because razor was not missi what was wrong wit like this. DON verificassist R42 to shave have staff find his ratoday. At 3:20 p.m. new razor in his but stand. DON verificarazor and had not stand. DON verificarazor and had not stand. DON verificarazor and procession of care or providing policy and procession of care or providing policy was provided SUGGESTED MET The director of nurs review and /or revisensure all residents toileting cares and locally develop monicompliance and repassurance and Per (QAPI) committee. ensure ongoing corrections with the control of	ng, but did not complete a he was a hoarder, and his ng. DON stated was not sure th R42, because he was nevered she had requested staff to e on Tuesday, and she would azor and assist him to shave DON reported staff found his cket in his room on the night a staff had not looked for the haven R42 after she but they were assisting him dure was requested for quality activities of daily living. No like policies and procedures to be policies and procedures to be received assistance with coathing. DON or designee toring systems to track port results to the Quality formance Improvement QAPI could conduct audits to impliance.	2 920			
21385	(21) days.	R CORRECTION: Twenty-one O Subp. 3 Infection Control;	21385			12/29/19
	Staff assistance Subp. 3. Staff assi Personnel must be infection control pro	istance with infection control. assigned to assist with the ogram, based on the needs of ursing home, to implement				12,23,10

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Millineso	ta Department of He	aiui	ı			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		00758	B. WING		11/12/2019	
NAME OF	DDO//DED OF OURSE/7=5		DDEGG CITY	TATE ZID OODE		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAR	RDENS AT CANNON F	FALLS	TH DOW STE			
		CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	Continued From pa	ge 109	21385			
	the policies and procedures of the infection control program.					
	by: Based on observati review, the facility fa of catheter bag and infection control sta resident (R20). In a ensure proper hand R20 during observa catheter (a catheter the bladder to drain Findings Include:	·		Corrected		
	his urinary catheter floor. The urine drain hooked under the was propelled himself at the television area, spout was out of the clamped and observed a.m. the drainage be	on 11/5/19, at 8:09 a.m. and tubing was dragging on the inage bag was uncovered and wheelchair as resident round the dining room area to back and forth. The emptying a holder although it was ved dragging on the floor. again on 11/06/19, at 10:36 ag was covered with a privacy				
	dragging on the floor Review of admission assessment dated of diagnoses that includementia; had an in	n Minimum Data Set (MDS) 8/14/19, indicated R20 had uded Alzheimer's disease and adwelling catheter and assistance with toilet use, bed				

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R20's admission record dated 8/7/19 indicated

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		00758		B. WING		I	C 12/2019
	PROVIDER OR SUPPLIER	FALLS	300 NOR	DRESS, CITY, S TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21385	Continued From particles and suprapubic cathete saline, pat dry, apptimes a day for cathete saline, pat dry, apptimes to chad a small bowel in gloves and sanitize sanitizer. LPN-E the dressing on the suptook off the old drest the dressing. LPN-I performing hand hy and cleansed the chapplied a new gauzall cares were compands at the sink. Nurse Manager, Resinterviewed on 11/0 stated R20 was on complete suprapuble expectations was the dragging on the bag should be kept verified the ProCare for incontinent care.	of retention of uring a neoplasm of the part of the pa	rostate. ealed R20 der dated normal ure two observed n 11/7/19, I used after R20 emoved nand ange the te. LPN-E tinage to gloves or e wet wipes wipes. PN-E then ace. After ed his I)-A was RN-A were to day. The hould not drainage N-A also be used	21385			
	LPN-E was intervie LPN-E stated the c site care was to cle apply gauze. LPN-E	urrent order for sup an with normal salir	rapubic ne and				

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STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		C 11/12/2019		
NAME OF PROVI	DER OR SUPPLIER	STREE	Γ ADDRESS, CITY,	STATE, ZIP CODE			
THE GARDEN	IS AT CANNON I	FALLS	ORTH DOW STE ON FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
use wet Ass (RN p.m Constant clear provents character to be a second se	istant Director of 1)-B, was intervious. RN-B verified introl Nurse. RN-f changed glove aning up after a viding care for the nge. RN-B explains and are infection was usually ever, agency position was usually ever, agency position in the formal for	and instead used the ProCar uprapubic site care. If Nursing, Registered Nurse iewed on 11/08/19, at 12:04 she was also the Infection B stated it was the expectat es and washed hands after bowel movement and befor ne suprapubic dressing ained Infection control ally done with facility staff, col staff were assumed to rol competencies prior to e facility. RN-B further state ave a system for training pointrol. facility policy entitled Infection for all Nursing Procedures, Precautions will be used in s. Standard precautions app es, secretions and excretions ash hands for 10 to 15 microbial or non-antimicrobi der the following conditions: ntact with blood, body fluids items potentially blood, body fluids or	e ion e d ol on the ly .				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			,
		00758	B. WING		1	<i>2</i> /2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	-ALIS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	Continued From page 112		21385			
	Time Period for Correction: Twenty-one (21) days.					
21426	MN St. Statute 144. Prevention And Con	A.04 Subd. 3 Tuberculosis ntrol	21426			12/29/19
	maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of extechnical assistance intation of the guidelines.				
	by: Based on interview facility failed to ensi screening compone newly admitted resi residents (R25) rec tuberculin skin test timeframe. The faci	and document review, the ure baseline tuberculosis (TB) ents were completed for 1 of 5 dents (R44) and 1 of 5 eived the second step (TST) within the required ility also failed to ensure completed and results		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00758		B. WING			C 12/2019
	PROVIDER OR SUPPLIER	FALLS	300 NOR	DRESS, CITY, S TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	Continued From paraccurately documents (E4) per current Center Prevention (CDC) repolicy. This had the residents residing instaff. Findings include:	nted for 2 of 6 en nter for Disease ecommendations potential to affec	Control and and facility at all	21426			
	R25 was admitted to received the first TS and then had the seadministered on 9/2 TST was read. Dur 1:00 p.m. with the at (ADON) indicated to early and agreed it least a week after forestering the search of the se	ST and had it rea econd two-step T 10/19, only four d ing interview on 1 assistant director he second TST w should have bee	d on 9/6/19, ST ays after first 1/8/19, at of nursing vas given too n given at				
	R44 was admitted the Although R44 receing assessment for curn TB history had been on 11/8/19, at 1:05 unable to find the shadown R44's medical reconstruction.	ved the two-step rent symptoms, r n completed. Dur p.m. ADON indic ymptom screen a	TST, no isk factors or ing interview ated she was and verified				
	E1 had a hire date of first-step TST on 10 then received a new with no second-step	0/3/19, that was r v first-step TST o	not read. E1 n 10/8/19,				
	E4 had a hire date of TST read on 6/11/1 when it was given. 6/26/19, with negating	9, but had no da E4 had second-s	te identified				
	During interview on indicated that E4's						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00758	B. WING		11/1	2/2019
	PROVIDER OR SUPPLIER	FALLS 300 NORT	DRESS, CITY, S TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDSHOUND THE APPROVED TO THE APPROVED	ULD BE	(X5) COMPLETE DATE
21426	as there was no ide ADON verified that TST and will be cor that the facility was on switching over to blood draw type of it problems with staff The facilities TB ris dated 11/12/18, inc was required at the workers in Minneso includes: (1) assess active TB disease, (3) testing for the properties of	entified date of administration. E1 had not had second-step impleted today. ADON stated working with medical director of Tuberculosis (TB) Gold testing as the facility had getting their TST read. It is assessment worksheet luded: baseline TB screening time of hire for all healthcare of a Baseline TB screening sing for current symptoms of (2) assessing TB history, and resence of infection with erculosis by administering berculin skin test (TST) or t. Tuberculosis, Screening of identified all resident shall be culosis infection and disease admission. Tuberculosis, Employee of identifies that newly hired sive a two-step TST to ensure	21426			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
711012711	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00758	B. WING		11/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON	FALLS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 115	21426			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21435	MN Rule 4658.0900 Recreation Program	O Subp. 1 Activity and n; General	21435			12/29/19
	Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program.					
	by: Based on observati review, the facility f centered, meaning	ent is not met as evidenced ion, interview and document ailed to provide person ful activities which included the facility for 1 of 3 residents activities.		Corrected		
	Findings include:					
	stated he was unab shopping activity du outings outside of t which conflicted wit R43 indicated it wa person item shoppi	ed on 11/4/19, at 6:55 p.m. and ble to attend the monthly ue to the facility scheduling the he facility on Wednesdays th R43's dialysis schedule. Is important for him to going for himself due to having an and not wanting staff and/or				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED	
			7 501251110.			C	
		00758	B. WING			12/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE			
THE GAI	RDENS AT CANNON	FALLS	TH DOW STF I FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21435	Continued From pa	ige 116	21435				
	shopping. R43 state nursing (DON) and about his desire to	doing his personal item ed he spoke to the director of the activities director (AD) participate in a shopping o changes and/ or follow-up					
	10/3/19, identified F diagnoses which in renal disease, perip diabetes mellitus. T	num Data Set (MDS) dated R43 had intact cognition and cluded anemia, end stage pheral vascular disease and The annual MDS further ry important" for R43 to do his					
	R43 had little time in activities and direct importance of social time, participation in R43's family to attest support participation types and locations daily schedule and	rised on 10/23/19, identified in the facility to participate in the staff to explain to R43 the all interaction, leisure activity in activities, invite/ encourage and activities with R43 to in, offer a variety of activity to maintain interests, modify treatment plan to vity participation as requested					
	10/2/19, indicated F and participation leblank, no intervention needed for R43 to plan remained curre	cipation Review effective R43's attendance preferences vel with activities was left ons and/ or adaptations participate in programs, care ent and appropriate, goals ventions remained effective.					
	8/2019, through 10, following: -R43's 8/2019, scho	dule was reviewed from /31/19, and revealed the edule indicated R43 g outdoors, watching TV and/					

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		00758	B. WING		11/1	; 2/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	11/1	2/2019
	RDENS AT CANNON I	300 NORT	H DOW STR	,		
THE OAI		CANNON	FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 117	21435			
	however lacked evi-R43's 9/2019, sche participated in one daily going outdoors-R43's 10/2019, scl participated in going games/ activity, how facility outing, howe outing.	sical games/ activity daily, dence of facility outing; edule indicated R43 facility outing on 9/19/19, and is and physical games/ activity; nedule indicated R43 goutdoors daily and physical wever lacked evidence of ever lacked evidence of facility				
	verified R43 had no outside of the facilit for a senior golf car attended a basebal enjoyed going outsi patio and visit with facility offered shop Wednesdays, howed due to R43's dialysi was aware R43 "me the facility shopping the facility, however worked best for the their staffing. AD exattempted to offer a	ever R43 was unable to attend is schedule. AD stated she entioned" he wanted to out of g and/ or to activities outside of r AD stated Wednesdays activities department due to explained she had not an alternate day for activities ey, however identified would be able to				
	and stated it was he try their best to make residents were able DON explained R43 outside of the facilit	ed on 11/8/19, at 12:11 p.m. er expectation for the facility to se accommodations so all e to participate in activities. 3 was able to attend an activity by over the summer, however to be rearranged to ensure				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION) DATE SURVEY COMPLETED	
			7. DOILDING.		С		
		00758	B. WING			2/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
THE GAR	RDENS AT CANNON I	FALLS	TH DOW STE FALLS, MN				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	· · · · · · · · · · · · · · · · · · ·			_D BE	COMPLETE DATE		
21435	Continued From pa	ge 118	21435				
	The facility activity provided.	policy was requested, but not					
	The administrator of review, and /or review ensure all residents activity assessment individualized, residents administrator of monitoring systems compliance and repassurance committed recommendations.	port those results to the quality					
21525	MN Rule 4658.1309 Consultation	5 A.B.C Pharmacist Service	21525			12/29/19	
	services of a pharm Board of Pharmacy A. provides cor provision of pharma home; B. establishes and disposition of a detail to enable an C. determines	a system of records of receipt all controlled drugs in sufficient accurate reconciliation; and that drug records are and that an account of all					
	by: Based on observati	ent is not met as evidenced on, interview and document ailed to ensure accurate		Corrected			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					l c l	
		00758	B. WING _			, 2/2019
		1 00700			1 11/1	2,2013
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THECA	DENC AT CANNON I	300 NORT	H DOW STR	REET		
THE GAI	RDENS AT CANNON I	CANNON	FALLS, MN	55009		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN.	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
21525	Continued From pa	ge 119	21525			
	narcotic documenta	ation for 6 of 7 (R23, R25,				
		1) residents. Additionally, the				
		ure a minimum of daily				
		rcotic counts on two days				
		November, 2019. In addition,				ļ
		ensure narcotics were				
		truction was monitored and				
		ntained for 1 of 1 resident				
		medication administration.				
	(102)					
	Findings include:					
	R23 R23's Minimum Data Set (MDS) identified diagnoses that included lymphedema and pain in her right leg and had significant cognitive impairment.					
	indicated R23 was	minophen 5-325 milligrams				
	signed out by nursing book for R23, hower documented in R23 doses were signed dated 10/24/19, idedose. The next three narcotic log were discheduled doses for 7:00 p.m. It appeared 10/24/19, was dated the 2:00 a.m. dosed discrepancies were nurse (LPN)-D during documents of the R23 d	and three doses of oxycodone ng staff in the narcotic sign-out ever four doses were 8's MAR. On 10/24/19, five out with the fifth (last) dose ntified as being the 2:00 a.m. ee doses signed out in the ated 10/25/19, for the usually or 7:00 a.m., 1:00 p.m., and ed the fifth dose signed out on d incorrectly and was actually for 10/25/19. These everified by licensed practical ng an interview on 11/8/19, at the director of nursing (DON)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/1	; 2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS	H DOW STF			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
21525	that included fracture disease, cirrhosis, a was cognitively intained and conversed an	a/11/19, identified diagnoses res in left foot, end stage liver and ascites. It indicated R25 let. and R25 was prescribed 5 mg of x hours for pain. also of oxycodone was signed sign-out book, however, two ented in R25's MAR. This erified by LPN-E during an 19. arthritis of the knee, low back ed pain, according to	21525			

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	NT OF DEFICIENCIES		(V2) MULTIPL	E CONSTRUCTION	I/V2) DATE	CLIDV/EV
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE COMP	LETED
			A. DUILDING:			
			D WINC		C	
		00758	B. WING		<u> 11/1</u>	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CAL	RDENS AT CANNON I	300 NOR	TH DOW STR	REET		
THE GAI	RDENS AT CANNON I	CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21525	Continued From pa	ge 121	21525			
	several pressure ul summary indicated	cers, and quadriplegia. The R36 was prescribed every four hours for chronic				
	entered into the nar doses were docume with two doses were p.m. and 10:00 p.m there were three do 6:00 p.m., and 10:0 doses left blank.	coses of oxycodone were recotic sign-out book, but four ented as given in R36's MAR e blank. On 10/17/19, the 4:00 doses were signed out, but uses documented at 4:00 p.m., 0 p.m There were three in 10/19/19, four doses were ix scheduled doses were MAR.				
		on 11/12/19, at 9:45 a.m. nese discrepancies in both				
	oxycodone five mgs 11/1/19, 11/5/19, 11 oxycodone five mg narcotic log two tim doses were docume of those days. The	ed R45 was prescribed so three times per day. On 1/6/19, and 11/7/19, R45 had doses signed out of the es each day. However, three ented in R45's MAR for each director of nursing (DON) epancies during an interview a.m				
	hydromorphone one chronic respiratory 10/14/19, and 10/15 out in the narcotic s were documented in and 10/17/19, five of	ed R51 was prescribed e mg every four hours for failure with hypoxia. On 5/19, four doses were signed sign-out book, but six doses n R51's MAR. On 10/16/19, doses were signed out and six if in the MAR. The DON				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00758	B. WING		11/1	; 2/2019		
NAME OF I		CTDEET AD		STATE ZID CODE	<u>'</u>			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
THE GARDENS AT CANNON FALLS			FALLS, MN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21525	Continued From pa	ae 122	21525					
	•	epancies during an interview						
	were reviewed on 1 accurate practice for counts. It was noted 100 missing signatures. The nar showed from 10:00 on 9/28/19, totaling signatures for 40 ho a.m. on 10/18/19, to were no signatures reconciliation was of	·						
	narcotic count on 1	missing signatures on the 1/8/19, at 9:45 a.m. and expectation that they should nd of every shift.						
	at 12:40 p.m. and c	vas interviewed on 11/12/19, confirmed there were no formal se and or documentation.						
	on 11/12/19, at 2:59 aware of the narcot any specifics. CP in quarterly quality conquarterly and is sch stated narcotics we were required to ha only two months con Typically, only one prescription was seindicated that there included in the phal	rmacist (CP) was interviewed 5 p.m. and stated he was ic diversion but did not know adicated that he attended the uncil meeting once each reduled for next week. CP are refilled on demand, but eve a provider order and that uld be ordered at a time. The pharmacist was a 10% audit process rmacy services, but the facility more robust service.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED		
				71. 501251110.			0
		00758		B. WING		l l	12/2019
NAME OF PROVID	DER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GARDENS AT CANNON FALLS				TH DOW STF FALLS, MN			
	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
The revision courshift command the I R32 had inclupuln annureces R32 incluas n R32 5/1/follo -R32 cont p.m. how regarmor -R32 note how regar to 10 according to 10 according R32 R32 R32	eived opioid sev 's Order Summ	olled Substance cated that nursice dications at the goff the shift a st make the correport any discorreport any discorreport any discorreport any discorreport any discorreport date and diagnoses sthma, chronic or chronic lungted R32 had freen out of severary Report date sulfate solution and/or shortnes (recotic Record viallet (narcotic se) dated 5/17/1 milliliters (ml) redical record lact count for the 8 lifate dated 10/1 ml remained; alfate dated 10/1 measured 1.00 clical record lact or the 4.75 ml string 1.00 ml	ing staff "must e end of each and a nurse unt together repancies to indicated R32 s which obstructive disease. The equent pain and a days. ed 11/12/19, every one hour ss of breath. vas reviewed ealed the eschedule II 19, at 12:42 remained, ked evidence 1.00 ml of 26/19, at 5:51 31/19, no time of ml remained, ked evidence from 10/26/19, dence of the at 9:16 a.m.	21525			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7. BOILDING.			:
		00758	B. WING			2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GA	RDENS AT CANNON	FΔIIS	TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21525	Continued From pa	ige 124	21525			
	shortness of breath	1.				
	R32 was observed on 11/12/19, at 9:16 a.m. calm and no signs of pain and/or shortness of breath.					
	a.m. and verified sh morphine sulfate da 10/31/19, with 1.00 she was unsure wh	ewed on 11/12/19, at 10:16 he was unable to locate R32's ated 5/17/19, with 8.00 ml and ml remaining. LPN-D stated at happened from 10/26/19, to g R32's 4.75 ml of morphine				
	DON was interviewed on 11/12/19, at 12:22 p.m. and verified R32's two bottles of morphine sulfate with 1.00 ml and 8.00 ml were "missing." DON explained LPN-D did not count those two bottles per their policy when she started her shift that morning. DON states she suspected the 1 ml was "thrown away," however was unsure about what happened with the 8.00 ml DON verified R32 did not have any medication disposition records on file. DON stated it was her expectation that all narcotics were reconciled at every shift change.					
	telephone on 11/12 per the board of ph two individuals at the	rmacist was interviewed via 1/19, at 2:57 p.m. and stated armacy it was expected for ne facility destroy narcotics per trail" should have been nof two years.				
	8/2/19, indicated th laws, regulations are to handling, storage of schedule II and of The policy indicated controlled medications.	ed Substances policy updated e facility would comply with all nd other requirements related e, disposal and documentation other controlled substances. d nursing staff must count ons at the end of each shift, an duty and the nurse going off				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00758	B. WING		11/1	; 2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALLS	TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21525	duty must make the investigate any discreconciliation to det the pharmacy and a needed legal action Destroying Medicatindicated medicatio accordance with fed The policy indicated substances would blocked area with resof. The policy indicates substances must have no longer than three Following medication record would include method and witness.	e count together. DON would crepancies in narcotic termine the cause and consult administrator to determine any n. The facility Discarding and tions policy adopted 8/12/19, ons would be disposed in deral and state regulations. If all unused controlled be retained in a securely stricted access until disposed ated disposal of controlled ave taken place immediately e days after discontinued. On destruction a disposition de reason for disposition, is signature. The medication would have been kept on file	21525			
	director of nursing (consultant pharmace procedures related ensure policies addidentification of loss medications. Facilit facility policies and designee could audensure staff complications could take the Quality Assurant (QAPI) committee fitime until the QAPI successful compliamonitoring.	THOD OF CORRECTION: The (DON) and/or designee and cist could review policies and to medication reconciliation to dress system for timely sor diversion of narcotic ty staff could be educated on procedures. The DON and/or dit medication reconciliation to fance. The DON and/or e those findings/education to for a determined amount of committee determines ance or the need for ongoing				

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(21) days.

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPIDENTIFICATION		, ,	E CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CONNECTION	IDENTIFICATION	NOWBEN.	A. BUILDING:		COIVII	LLILD
		00758		B. WING		C 11/12/2019	
		007 90				1 11/1	12/2013
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALLS		TH DOW STF FALLS, MN			
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENC			PROVIDER'S PLAN OF CORRECT	ION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE	LD BE	(X5) COMPLETE DATE
21830	830 MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights			21830			12/29/19
	Subd. 10. Particip notification of family		reatment;				
	unconscious or con communicate, the f efforts as required either a family mem writing by the reside an emergency that admitted to the faci family member to p	neir health care. To unity to discuss tree dividual caregivers, est and participate and the right to include the chosen representation of the resident casember or other replent may be included who enters a facility ander paragraph (other or a person depart as the person to the resident has builty. The facility shally.	This right eatment and the in formal lude a sentative or annot be presentative ed in such by is eato reasonable c) to notify esignated in the contact in een all allow the interest and in the interest and interest				
	planning, unless the to believe the reside directive to the conspecified in writing member included in notifying a family m	ent has an effective trary or knows the that they do not wan treatment plannir ember but prior to	e advance resident has ant a family ng. After allowing a				
	family member to p planning, the facility efforts, consistent v practice, to determi executed an advan- esident's health car this paragraph, "rea (1) examining the	must make reason make reason with reasonable me if the resident had been directive relative edecisions. For part of the control of the contro	onable edical has e to the ourposes of hclude:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	00758		B. WING			2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE CAL	DDENC AT CANNON	300 NORT	H DOW STR	REET		
THE GARDENS AT CANNON FALLS CANNON			FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21830	Continued From pa	ge 127	21830			
21030	resident; (2) examining the resident in the posses (3) inquiring of an family member con whether the resider directive and whether the resider directive and whether the resident normally gwhether the resider directive. If a facilit designated emerge member to participa accordance with the liable to resident for the notification of the mergency contact family member was patient's privacy rig (c) In making reafamily member or a design examining the persand the medical reconsession of the facility a family memergency contact admission, the facil social service agen agency that the rest the facility has been member or designate county social service inforcement agency identifying and notification of the facility in the rest the facility has been member or designate ounty social service agency identifying and notification of the facility has been member or designate ounty social service agency identifying and notification.	e medical records of the session of the facility; ny emergency contact or tacted under this section at has executed an advance ser the resident has a the resident normally goes for the physician to whom the ses for care, if known, at has executed an advance sy notifies a family member or ency contact or allows a family ate in treatment planning in the paragraph, the facility is not a damages on the grounds that the family member or or the participation of the simproper or violated the	21000			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		C	
		00758	B. WING			<i>,</i> 2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STF FALLS, MN			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
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21830	Continued From pa	ge 128	21830			
	that assists a facility subdivision is not like damages on the gro the family member	ocal law enforcement agency y in implementing this able to the resident for bunds that the notification of or emergency contact or the family member was improper ent's privacy rights.				
	This MN Requirement is not met as evidenced					
	by: Based on observation, interview and document review, the facility failed to accommodate resident preference for bedtime for 1 of 2 residents (R46) reviewed for choices.			Corrected		
	Findings include:					
	R46's Annual Minimum Data Set (MDS) dated 10/4/19, indicated R46's cognition was intact with a diagnosis of paraplegia (paralysis of the lower body). R46's Annual MDS indicated R46 was totally dependent on two staff assistance with transfers and needed extensive assistance of two staff with dressing, toileting, grooming, bathing. R46's MDS for Interview for Daily Preferences was left unanswered for the interview question "How important to choose your own bedtime?" and it was marked with a hyphen (-).					
		on 11/4/19, at 6:06 p.m. sitting //c) in his room with his call s door.				
	room two times with - At 6:17 p.m. direct hallway and told reg	p.m. a staff walked by R46's nout entering R46's room. tor of nursing (DON) stood in gistered nurse (RN)-A to ght and to see what R46				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
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		00758	B. WING			
		00756			11/1	2/2019
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THE GA	RDENS AT CANNON I	FALLS	FALLS, MN			
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TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
		·		DEFICIENCY)		
04000	0 " 15	100	04000			
21830	Continued From pa	ge 129	21830			
	needed RN-A (who	o is also nurse manager)				
		and exited and left call light				
	on.	r and oxited and fort ean light				
		propelled himself in his w/c out				
		hall with his call light still on.				
		said to unidentified nursing				
		nose call light is on?" NA told				
		aiting to go to bed but R10's				
		d she wanted staff assistance				
		and spilled a coca cola all				
		so wanted assistance to go to				
		NA to go and hook up R46 to				
		vent and told R10 she would				
	be helped after R46					
		nidentified staff walked past				
	•	g a resident in a w/c without				
		needed. At 6:25 p.m. there				
		activated on in the 200				
		was seated in her office, and				
		B and licensed practical nurse				
		ng to each other at nurse				
		A-G, "I will meet you in R46's				
	room."	,, t G, 1 mm most yea m 1 t 10 c				
		inidentified NAs entered R4's				
	room with the trans					
		entered R23's room and told				
		d to wait and staff would help				
		nere are people [residents]				
	ahead of you."					
		entered R46's room and				
		s ready for bed. R46 stated the				
		room with the lift. R46 he was				
		get into bed and his program				
	Chicago PD was co					
		s call light over his door went				
	off, DON was in R4					
		exited R46's room and stated				
		ee how much longer it would				
	take to get him assi					
		was observed sitting in his w/c				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		00758	B. WING		11/12/2019	
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
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	OLIMAN AND DV OTA					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
21830	Continued From no	ngo 120	21830			
21030	Continued From pa	ige 130	21030			
	at nurse station yell	ling, "Help! Help!"				
	- At 6:30 p.m. DON	I entered an unidentified room				
	number which had	call light on above door and				
		all light still activated.				
		was observed sitting in his w/c				
		for assistance to bed with call				
	light on.					
		were no call lights activated				
	in hall 200	S .				
	- At 6:33 p.m. R46	was observed still waiting in				
	his room to go to be					
		and R54's call lights came on				
	over their room doo					
	- At 6:40 p.m. R46	wheeled himself out of his				
		ooking down hallway. RN-A				
		get R46 hooked up to the lift				
	while he was waitin					
		was observed sitting in his w/c				
		N-A present hooked up to the				
	transfer lift.					
		valked into R46's room to				
		sfer R46 to bed. (R46 waited				
	41 minutes for staff					
		,				
	During interview on	ı 11/4/19, at 7:18 p.m. R46				
		o go to bed at 6:00 p.m. every				
		ually "waited that long all the				
	time to go to bed, it					
	,					
	RN-A nurse manag	ger, stated on 11/7/19, at 2:26				
		to bed at 6:00 p.m. and all				
		l-A stated R46's preferred				
		entified on R46's NA care				
		st know by word of mouth."				
	. ,	•				
	R46's careplan date	ed 11/7/19, did not include				
		or bedtime at 6:00 p.m				
	,	1				
	DON stated on 11/7	7/19, at 2:45 p.m. that R46				

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could go to bed at 6:00 p.m. as it was his

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00758	B. WING			C 1 2/2019
	PROVIDER OR SUPPLIER	SALLS 300 NORT	DRESS, CITY, S TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21830	preference. DON staccommodate this accommodate this accommodate this accommodate this accommodate this accommodate. Facility policy Self I Participation dated would be allowed to consistent with their including sleeping, facilitate resident chinformation about reupon initial assessmentereafter, and doct the medical record. SUGGESTED MET The director of nurseducate staff regard with plan of care. Do and implement policy resident preference care plans could be residents' preference.	cated staff should and follow residents' careplan. Determination and 7/25/16, indicated residents of choose schedules that are rinterest for daily routine. The policy indicated to noices staff would gather esidents' personal preferences ment and periodically ument these preferences in SHOD OF CORRECTION: sing (DON) or designee could ding residents' preferences. ON or designee could develop by and procedure regarding with plan of care. Audits of a done routinely to ensure	21830			
21840	Residents of HC Farsubda. 12. Right to residents shall have based on the inform 9. Residents who ror dietary restriction likely medical or mathe refusal, with documedical record. In coincapable of undersidents	651 Subd. 12 Patients & ac.Bill of Rights orefuse care. Competent entering the right to refuse treatment nation required in subdivision efuse treatment, medication, as shall be informed of the ajor psychological results of cumentation in the individual cases where a resident is standing the circumstances but icated incompetent, or when	21840			12/29/19

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		I COMP	LETED
						:
		00758	B. WING			2/2019
						2/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALLS	TH DOW STE			
		CANNON	FALLS, MN	55009		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	NEODE WORLD	iso is a remaining in the state of the state	TAG	DEFICIENCY)	10,112	
04040		400	0.10.10			
21840	Continued From pa	ige 132	21840			
	legal requirements	limit the right to refuse				
		ditions and circumstances shall				
		d by the attending physician in				
	the resident's media					
		ent is not met as evidenced				
	by:					
		ion, interview and document		Corrected		
		ailed to ensure an accurate				
		d to include appropriate code				
		wishes for life-saving				
		ent) regarding cardio				
		ation (CPR) for 1 of 12				
	residents (R42) rev	riewed for Advance Directives.				
	Findings include:					
	i indingo inolado.					
	R42's EMR (electro	onic medical record) was				
		/19. R42's EMR identified he				
	was full-code status	s (indication to initiate CPR).				
		,				
	R42's physician ord	ders dated 10/31/19, identified				
	R42 had full code s	status.				
	D 401 = 105 / 15 = 5					
		sician Order for Life Sustaining				
) identified R42's code status				
		not resuscitate/do not				
	,	ST form was signed by				
		RN)-A and R42's physician, and				
		nt POLST in R42's EMR.				
	K42's signature wa	s not written on the document.				
	Interview on 11/5/10	0 at 1:42 n m with licensed				
		9, at 1:42 p.m. with licensed N)-D identified R42's EMR				
		full code status. LPN-D stated				
		quickest way to identify code				
		n R42's EMR. If the code				
		itified in R42's EMR, LPN-D				
		e most recent POLST in the				
	שומוכט שווכ עשכט ווול	S INOSCIECENCE OLO I III (IIE				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00758		B. WING		C 11/12/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALLS	H DOW STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21840	Continued From pa	ge 133	21840			
	EMR scanned docu	uments.				
		11/5/19, at 1:54 p.m. R42 be resuscitated if he stops eart stops.				
		viewed again on 11/5/19. The 's code was DNR/DNI.				
	RN-A verified she we POLST indicating hand agreed it could	11/5/19, at 4:10 p.m. with was unsure why R42 had a see was DNR/DNI in the chart, cause R42 to receive the ion measures if he had crest.				
	11/5/19, at 4:14 p.n staff to follow the P resuscitative meast according to reside verified R42 continu full-code status. DC changed R42's code electronic medical in 5/23/19, POLST. Reparty and was re-in remain full code, so be changed back to agreed staff had the	sing (DON) was interviewed on n. and stated she expected the OLST to ensure appropriate ures were implemented nt and family choices. DON used to choose to maintain DN confirmed she had just e status to DNR in his record after reviewing his 42 was his own responsible terviewed, and chose to this code status was going to be full-code in the EMR. DON the potential to deliver the ive measures with conflicting ocumentation.				
	stated she was the coordinator, and wa and orientation. She about the crash car status. SD stated s	11/5/19, at 4:21 p.m. RN-B staff development (SD) as responsible for staff training e instructed new licensed staff traind where to identify code he expected staff to use the rather than information from				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			B 14/11/0			С	
		00758	B. WING		11/	12/2019	
	PROVIDER OR SUPPLIER	FALLS 300 NOR	DDRESS, CITY, S TTH DOW STR N FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
21840		ge 134 he POLST was the most	21840				
	accurate and currer resident's code state role for about a year was responsible for staff about the facility's code status RN-B was not familistatus policies and reviewed with staff Additionally, RN-B documentation code	nt document identifying a tus. She had worked in her ar, and was unsure how or who educating existing licensed ity's crash cart, and the spolicies and procedures. liar with the facility's code procedures, which were not on a routine basis.					
	-A indicated resider complete advanced POLST was provide residents to establist directives upon adreviewed quarterly, with significant chathospitalization. The responsible for upd of each resident's cresponsible to ensuguardian decisions necessary signaturupdated and accurate and physician any additional procaccurate code state wishes were review conferences and he stated at one point to DNR Status, but	p.m. the social worker (SW) and were encouraged to directives upon admission. A sed and reviewed with new sh code status and health care mission. Code status was and on an as-needed basis, anges in status, and after an urse managers (NM) were ating and ensuring accuracy code status. NM were also are the resident and/or were documented with all les, included on the POLST, ate in the residents EMR, care orders. SW-A was unsure of esses in place to ensure as documentation. R42's are at quarterly care at chose to be full code. SW-A R42 was agreeable to change was unsure if his status had R42 was his own person, and					
	made his own decis	sions regarding medical rified R42's most recent					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
				A. BUILDING:				
		00758		B. WING		11	C / 12/2019	
NAME OF PROVIDER O	R SUPPLIER	Ş	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GARDENS AT	THE GARDENS AT CANNON FALLS			TH DOW STR FALLS, MN				
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
POLST in but was of physician DNR/DN was unsusting attress signature. The Advindicated responsil procedur status was hospital, directive the information physician Directive readmissing quarterly POLST in resident of change pauthorized regarding responsil upon adriance staff reference of code is a process status. The Emerican Resuscit indicated incorporation in the component of the component in	anced Directive red a resident support and outsite store and outsite store and outsite store are a resident at the social basis, with a formation was basis, with a formation and a basis, with a formation and a basis, with a formation and a basis, with a formation and birective are a resident at the store are a resident and outsite staff to a staff to	age 135 Ridentified him as DNR d by RN-A and R42's as unaware the POLST ed in R42's medical reclacked the resident/gual ectives policy dated 1/9 I service director was elementing and coording in residents' code statud verbally from the residence, or resident advance of the example of the ex	or for cord, ardian of 19, ating as. Code dent, aced status, for on care. led to all able were not aff aterials ents estions, amily, icy did are event identify code ary 8/3/16, CPR	21840				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMF			LETED
	00758	B. WING			2/2019
	FALLS 300 NOF	RTH DOW STI	REET		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
Cardiovascular Carsaving) training maprocedure did not in obtained resident coresident cardiopulm the facility was to copractice responding. SUGGESTED MET The director of nursidevelop, review, an procedures related resuscitation status ensure all areas in are consistent. The educate all appropring procedures. The Domonitoring systems compliance.	e for facility BLS (basic life terial. The policy and nelude a process for how staff ode status in the event of nonary arrest. It also indicated onduct periodic mock codes to to an arrest. THOD OF CORRECTION: Sing (DON) or designee could d/or revise policies and to resident wishes for and ensure a process to the residents medical record DON or designee could iate staff on the policies and DN or designee could develop to ensure ongoing				
Residents of HC Fa Subd. 18. Respor residents shall have reasonable respons requests. This MN Requirement by: Based on observati review, the facility fa and/or resolve griev	nsive service. Patients and ethe right to a prompt and se to their questions and ent is not met as evidenced on, interview and document ailed to promptly respond to vances for long call light wait	21870	Corrected		12/29/19
	Continued From pa Cardiovascular Carsaving) training may procedure did not in obtained resident cardiopulm the facility was to continued responding SUGGESTED MET The director of nursidevelop, review, an procedures related resuscitation status ensure all areas in a re consistent. The educate all appropriocedures. The Domonitoring systems compliance. TIME PERIOD FOR days. MN St. Statute 144. Residents of HC Facus Subd. 18. Response requests. This MN Requirements by: Based on observation review, the facility facus for 8 of 9 residents for 8 of 9 res	PROVIDER OR SUPPLIER RDENS AT CANNON FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 136 Cardiovascular Care for facility BLS (basic life saving) training material. The policy and procedure did not include a process for how staff obtained resident code status in the event of resident cardiopulmonary arrest. It also indicated the facility was to conduct periodic mock codes to practice responding to an arrest. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to resident wishes for resuscitation status and ensure a process to ensure all areas in the residents medical record are consistent. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days. MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced	ROUNDER OR SUPPLIER ROENS AT CANNON FALLS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 136 Cardiovascular Care for facility BLS (basic life saving) training material. The policy and procedure did not include a process for how staff obtained resident code status in the event of resident cardiopulmonary arrest. It also indicated the facility was to conduct periodic mock codes to practice responding to an arrest. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to residents medical record are consistent. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days. MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to promptly respond to and/or resolve grievances for long call light wait times for 8 of 9 residents (R1, R3, R12, R51,	OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: B. WING B. WING	OF CORRECTION DIENTIFICATION NUMBER: 00758 B. WING B. WING COMP CONTROL OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL RESULATORY OF LSC IDENTIFYING INFORMATION) COntinued From page 136 Cardiovascular Care for facility BLS (basic life saving) training material. The policy and procedure did not include a process for how staff obtained resident code status in the event of resident cardiopulmonary arrest. It also indicated the facility was to conduct periodic mock codes to practice responding to an arrest. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to resident wishes for resuscitation status and ensure a process to ensure all areas in the resident smedical record are consistent. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days. MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to promptly respond to and/or resolve grievances for long call light wait times for 8 of 9 residents (R1, R3, R12, R51,

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00750	B. WING		C	
		00758	b. WING		11/1	2/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21870	Continued From pa	ge 137	21870			
	2:08 p.m. R1, R3, F stated they waited a to be answered, up waited for staff assi R18, R24, R37 stat problem in the facili getting worse the la stated nothing had with the problem. Resident Council (F identified residents expressed call light timely manner. RC assistants (NA)s tuignored residents was stated to the stated nothing had with the problem.	ancil meeting on 11/6/19, at R12, R51, R18, R24, R37 a long time for their call lights to an hour and longer they stance. R1, R3, R12, R51, ed long call lights had been a fity since last spring, and was lest couple of months, and been changed or done to help RC) minutes dated 4/24/19, present at the April meeting s were not answered in a members stated nursing rned off the call lights and tho activated their call lights.				
		ce reports identified no report resident council complaints concerns.				
	lights not being ans turned off with no a	5/29/19, identified long call wered at meals and still being ssistance provided. A letter anding to RC members did not with call lights.				
	not being answered minutes to 1 hour for	6/26/19, identified call lights I in a timely manner waiting 45 or staff assistance, and staff ights without talking to the ing assistance.				
	were frustrated ove	7/31/19, identified residents r no resolution to the same and nothing being done about				

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
,	o. cozo		A. BUILDING:				
		00758	B. WING		11/1	, 2/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GAI	RDENS AT CANNON F	ΕΔΙΙ S	TH DOW STR FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
21870	Continued From page 138		21870				
	them.						
	RC minutes dated 8 regarding call lights	3/28/19, did not note anything or staffing.					
	RC minutes dated 9 regarding call lights	9/25/19, did not note anything or staffing.					
		10/10/19, identified there had lone for long call light wait aviors.					
	RC minutes dated 10/30/19, identified medications had not been given timely and identified no follow up had been done regarding long call light wait times and staff behaviors.						
	During interview with DON on 11/8/19, at 1:02 p.m. DON stated nursing had completed no audits to determine staff response time for resident request for staff assistance with the call lights.						
	at 2:28 p.m. he stat RC minutes and sta was responsible for residents at the mo stated no call light a	th administrator on 11/12/19, ed he did not read the monthly ated each department head follow up with concerns from nthly meetings. Administrator audits had been completed concerns with long call light essistance.					
	indicated staff would	ted, Answering the Call Light d answer residents' call lights e and respond to residents'					
	facility encouraged	ated 10/10/19, indicated the all residents to utilize the s an opportunity to meet with					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00758	B. WING		11/1	2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21870	other residents to day The policy indicated addressed in a satist SUGGESTED MET The administrator or revise facility system in the resident cour manner. The adminieducate all appropriassurance (QAA) to systems to ensure or report those results for further recommendation of the facility	iscuss any area of concern. It residents' concerns would be sfactory and timely manner. IHOD OF CORRECTION: It designee could review and ms, to ensure voiced concerns acil were addressed in a timely histrator or designee could iate staff. The quality earn could develop auditing ongoing compliance and to the quality assurance team endations. IN CORRECTION: Twenty-one IN CORRECTION: Twenty-one	21870			12/29/19
	Every acute care	inpatient facility, every				

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Milliesc	ita Department of He	ealti				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u></u>	COMPLETED	
					l c	<u> </u>
		00758	B. WING			, 2/2019
		00730			1 1/1	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		300 NOR1	TH DOW STR	REET		
THE GAI	RDENS AT CANNON I	FALLS CANNON	FALLS, MN	55009		
(V4) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION)NI	()(5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
21880	Continued From pa	ge 140	21880			
21000	-		2.000			
		n as defined in section				
		acute care facility, and every				
		ore than two people that				
		mental health services shall				
	have a written inter	rnal grievance procedure that,				
		forth the process to be				
		time limits, including time				
		ponse; provides for the patient				
		the assistance of an				
		a written response to written				
		ovides for a timely decision by				
		n maker if the grievance is not				
		Compliance by hospitals,				
		ns as defined in section				
		hospital-based primary				
		s, and outpatient surgery				
		n 144.691 and compliance by				
		e organizations with section				
		to be compliance with the				
	requirement for a w	ritten internal grievance				
	procedure.					
	This MN Requireme	ent is not met as evidenced				
	by:					
	Based on observati	on, interview and document		Corrected		
	review, the facility fa	ailed to follow up on a report of				
	a missing ring for 1	of 2 residents (R25) reviewed				
	for missing persona	al property.				
	Findings include:					
	_					
	R254's Minimum Da	ata Set (MDS) dated 9/30/19,				
	indicated R254 was	admitted on 9/26/19, from the				
	hospital with diagn	oses that included alcoholic				
	hepatitis and withdr	awal, depression, and muscle				
	weakness after falli	ng at home and hitting his				
		licated R254 was cognitively				

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Minneso	ta Department of He	ealth	_		_	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00758	B. WING		11/1	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALLS	TH DOW STE I FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21880	and stated he was a increase strength whome. During an imp.m. R254 indicated the top drawer of the R254 stated the ring sandwich-sized plasmissing in mid Octors gold with an ame R254 stated the ring wedding ring from his father's and his the cost of the ring the ring was mostly stated the missing in Director of Social Soci	ved on 11/4/19, at 1:54 p.m. there for physical therapy to with a plan to discharge to terview on 11/4/19, at 4:30 d he was missing a ring from he nightstand next to the bed. g had been in a stic baggie and noticed it was ober. R254 described the ring ethyst center stone missing. g had been his father's 1945 and the stone was both birthstone. R254 estimated to be \$200. R254 indicated of sentimental value. R254 ring was reported to the services (DSS) when he ing but was told there was be done. R254 also stated he				
		I were interviewed on 11/7/19, either were not aware of a				

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AND PLAN OF CORRECTION IDENTIFICATION NOWIBER. A. BUILDING:	
	2/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
THE GARDENS AT CANNON FALLS 300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R254 was interviewed again on 11/7/19, at 2:44 p.m. and confirmed the ring loss was reported to DSS, but there was no offer of replacement or payment for the loss. R254 believed it was lost in mid October. Record review revealed that there was no missing property inventory and there was no evidence a report of the missing ring entered into the missing personal property log. DSS affirmed on 11/8/19, at 9:25 a.m. that the ring was not included on R254's personal property inventory on admission, but she verified that there was no inventory included in R254's record. She stated the form may have been sent to Medical Records and indicated she requested. it. DSS stated this loss would have been discussed at the leadership morning meeting, but was unable to find any documentation of the discussion. DSS indicated R254 would have been reimbursed if the item had been listed on the inventory. A voice mail message was left for R254's son on 11/08/19, at 1:09 p.m.; however, the phone call was not returned. The administrator was interviewed on 11/12/19, at 7:36 a.m. and stated he was made aware of the missing ring at least a month ago. He indicated missing items were reviewed at the morning leadership meetings and was aware it had not been documented on R254's personal property inventory. The administrator indicated the policy states the facility would not have accountability if the item had not been on the signed inventory list. The administrator stated typically a claim of a missing item would be investigated and a police report would have been	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			,
		00758	B. WING			<i>2</i> /2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALLS	H DOW STE			
		CANNON	FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 143	21880			
	made for any item was confused where administrator indicated to with administrator and one had seen the usually contact hos sent with the resided DSS should have to DSS was interviewed.	valued at \$50 or greater. R254 in admitted and the ated the family should have verify the item was missing. Ilso stated he was confident ering and the facility did not pitals to see if the item was ent. The administrator indicated aken a few more steps.				
		e the family had not been S was not able to produce the eventory.				
	outlined that missin directed to the DSS included investigation surrounding the iss	ce Policy dated 10/10/2019, g article grievances are and the follow up process on of specific details ue of concern, with the goal of olving the concerns.				
	The director of nurs develop, review, an procedures to ensu aware of grievance The DON or design appropriate staff. To develop monitoring	THODS OF CORRECTION: sing (DON) or designee could d /or revise policies and re all residents and staff are process and follow through. He could educate all the DON or designee could systems to ensure ongoing port those results to the quality ee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			12/29/19

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Minnesota Department of Health						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAIN	OF SOURCE HOIN	IDENTIFICATION NOIVIDEN.	A. BUILDING:		CONF	
					С	
		00758	B. WING			2/2019
= -:						
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE GAR	RDENS AT CANNON I	FALIS	TH DOW STE			
0,		CANNON	FALLS, MN	55009		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
TAG	NEGOLATORI ORE	SO IDENTIF TING IN ORWATION)	TAG	DEFICIENCY)	MAIL	57.1.2
21995	Continued From pa	ige 144	21995			
	Subd 4a Interna	l reporting of maltreatment.				
		all establish and enforce an				
		ocedure in compliance with				
		rules to ensure that all cases				
		eatment are reported. If a				
		nal reporting procedure, a				
		may meet the reporting				
		s section by reporting				
		r, the facility remains				
		nplying with the immediate				
	reporting requireme	ents of this section.				
	This MN Dequirem	ant is not mat as avidenced				
		ent is not met as evidenced				
	by:	ion, interview and document		Corrected		
		ailed to report timely an		Corrected		
		atment to the State Agency				
		dents (R41) reviewed for				
	physical abuse.	()				
	' '					
	Findings include:					
	The director of nurs	sing (DON) was interviewed on				
		n. and stated on 11/2/19, at				
		informed by the nursing				
	•	at licensed practical nurse				
		h" with R41 the other night.				
		-B indicated "he felt likewas				
	rough." DON stated	d it did not seem as serious				
		ed it and after DON talked				
		tor they decided it did not need				
		e SA. DON indicated LPN-A				
		r staff were not interviewed at				
	that time.					
	DON 46!-4:4	discrete of manager - (ADON)				
	DON, the assistant and NA-B were inte p.m. and NA-B stat to ADON that a few	director of nursing (ADON) erviewed on 11/5/19, at 5:06 red on 11/2/19, it was reported v evenings ago NA-B observed ical" and "rough" with R41.				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		PLETED
		00758	B. WING			C I 2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE GA	RDENS AT CANNON	FALLS	TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	NA-B explained R4 touched and LPN-A handled" R41 as R. her. NA-B stated R me alone leave me arms inward, howe indicated LPN-A as changing R41 out oboth LPN-A and NAR41 while "pulling had DON confirmed the rof concerns regular LPN-A to R41. ADO notified DON whom NA-B stated he did rough treatment to been a newer staff about retaliation from DON was interview and verified a report any allegation and/or SA within two R41 was interviewed was unable to answord R41's Quarterly Min 8/26/19, identified Fimpairment and dia dementia and Park MDS indicated R41 assistance with act.	A continued on and "man 41 was "begging not to touch" 41 repeatedly yelled, "leave alone" as R41 tightened her ver LPN-A did not stop. NA-B sked NA-D to assist with of urine soaked clothing and A-D continued "manhandling" her clothes off against her will." hat on 11/2/19, NA-B notified garding "rough" care from DN stated she and NA-B asaid it was not reportable. not report the concern of R41 right away due to having at the facility and worried born LPN-A. The ded on 11/6/19, at 10:35 a.m. art regarding an allegation of a submitted to the SA on the did was their expectation to the of abuse to the administrator to hours.		DEFICIENCY		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74401 1544	or contraction	IDENTIFICATION NONDER.	A. BUILDING:			
		00758	B. WING			2/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON	FALLS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	free from abuse an condone any form of indicated any indiviversident abuse or smust immediately radministrator, DON incident of resident confirmed the incident of facility management lapse. The policy for would report suspectimely manner to approcedures regarding mistreatment. The could re-educate all procedures. The administrator of procedures and pro	d the facility would not of resident abuse. The policy dual observing an incident of uspecting resident abuse eport such incident to the lor change nurse and when an abuse was suspected or ent must have been reported ent regardless of the time wither indicated the facility cited or identified abuse in a propriate agencies. THOD OF CORRECTION: could review policies and and reporting of all alleged administrator and or designee, I staff on the policies and diministrator could develop a to ensure ongoing compliance.	21995			
22000	Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may and a statement of to minimize the risk	s population identifying encourage or permit abuse, specific measures to be taken tof abuse. The plan shall es governing the plan	22000			12/29/19

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:			С	
		00758	B. WING			2/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE GAI	RDENS AT CANNON	FALLS	TH DOW STF FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
22000	agency and person providers, shall dev prevention plan for residing there or re. The plan shall cont assessment of: (1) abuse by other indivulnerable adults; (other vulnerable adults; (other vulnerable adults. For the purterm "abuse" include (c) If the facility, and personal care a knows that the vuln violent crime or an toward others, the inplan must detail the minimize the risk the reasonably be experiently and persons unsupervised. Under the plan must detail the minimize the risk the reasonably and persons unsupervised. Under the plan must detail the minimize the risk the reasonably be experiently and persons unsupervised. Under the plan must detail the minimize the risk the reasonably of a vulnerable adult misconduct or physich information from authority or through another facility, and	including a home health care all care attendant services relop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the terson and other vulnerable poses of this paragraph, the	22000				
	by:	ent is not met as evidenced on, interview and document		Corrected			

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 t. BOILBII (O.			:
		00758	B. WING 11/12/.		2/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GAI	RDENS AT CANNON I	FALLS	H DOW STR			
0(1) ID	CHMMA DV CTA		FALLS, MN		DNI .	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 148	22000			
	review, the facility failed to thoroughly investigate and provide protection following an allegation of mistreatment for 1 of 5 residents (R41) reviewed for employee physical abuse.					
	Findings include:					
	The director of nursing (DON) was interviewed on 11/5/19, at 4:57 p.m. and stated on 11/2/19, at 2:30 p.m. she was informed by the nursing assistant (NA)-B that licensed practical nurse (LPN)-A was "rough" with R41 the other night. DON explained NA-B indicated "he felt likewas rough." DON stated it did not seem as serious when NA-B explained it and after DON talked with the administrator they decided it did not need to be investigated any further. DON indicated LPN-A and/or R41 or other staff were not interviewed at that time. DON further indicated R41's cares and interactions between staff and resident were not observed. Furthermore, DON confirmed LPN-A and/or NA-D were allowed to remain working following the allegation made on 11/2/19.					
	NA-B were interview NA-B stated on 11/that a few evenings "being physical" and explained R41 was LPN-A continued of R41 was "begging R41 repeatedly yell alone" as R41 tight however NA-B indicated LPN changing R41 out of both LPN-A and NA-B indicated NA-B indicated LPN changing R41 out of both LPN-A and NA-B indicated LPN changing R41 out of both LPN-A and NA-B indicated LPN changing R41 out of both LPN-A and NA-B indicated LPN-A and NA-B indi	ector of nursing (ADON) and wed on 11/5/19, at 5:06 p.m. 2/19, it was reported to ADON ago NA-B observed LPN-Ad "rough" with R41. NA-B asking not to be touched and n and "man handled" R41 as not to touch" her. NA-B stated ed "leave me alone leave me ened her arms inward, cated LPN-A did not stop. N-A asked NA-D to assist with of urine soaked clothing and A-D continued "manhandling" her clothes off against her will."				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE S COMPLE		
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		00758	B. WING		1	/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CAL	THE GARDENS AT CANNON FALLS 300 NORTH DOW STREET					
THE GAI	RDENS AT CANNON I	CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 149	22000			
	ADON confirmed or concerns regarding R41. ADON stated	n 11/2/19, NA-B notified her of "rough" care from LPN-A to she and NA-B notified DON er follow-up was needed.				
	and verified the faci allegation of physics NA-D were placed of stated it was their e investigating and ob- unit following an alle	oserving cares/ monitoring the egation of physical abuse. d on 11/7/19, at 6:49 a.m. and				
	8/26/19, identified F impairment and dia dementia and Parki	nimum Data Set (MDS) dated R41 had severe cognitive gnoses which included nson's disease. The Quarterly required extensive staff vities of daily living.				
	9/27/19, indicated a or infliction of harm The policy indicated free from abuse and condone any form of indicated any individual resident abuse or simust immediately readministrator, DON incident of resident confirmed the incident of facility managem lapse. The policy in suspected resident reported the facility SA and begin investigations.	Policy and Procedure adopted abuse referred to mistreatment by someone to an individual. It residents had the right to be did the facility would not of resident abuse. The policy dual observing an incident of uspecting resident abuse eport such incident to the or change nurse and when an abuse was suspected or ent must have been reported ent regardless of the time dicates when an incident of abuse or mistreatment was would initiate a report to the tigation of the alleged incident entress reports, staff				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00758	B. WING		11/1	; 2/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE GA	RDENS AT CANNON I	-ALIS	TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	interviews and inter Furthermore, the potential facility whom has abuse would be sust outcome of the invention of the inventi	view other residents. blicy indicated employees of ad been accused of resident spended immediately pending estigation. THOD OF CORRECTION: bould review policies and ng reporting and investigating eglect/mistreatment. The r designee, could re-educate ies and procedures. The develop a monitoring system	22000			

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