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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SW7U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00758

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2016**

6. DATE OF SURVEY **01/17/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **89** (L18)
13.Total Certified Beds **89** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Effective December 29, 2019, due to15 beds being relicensed, the number of licensed and certified beds in your facility are increased from 74 beds to 89 beds in accordance with a change in licensure. After this change they will have zero (0) beds on layaway.

17. SURVEYOR SIGNATURE Date :
Eva Loch, Unit Supervisor 01/24/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 01/24/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/07/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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
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

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
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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SW7U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00758

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(L1) **245304**

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

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(L3) **THE GARDENS AT CANNON FALLS**
(L4) **300 NORTH DOW STREET**
(L5) **CANNON FALLS, MN** (L6) **55009**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2016**

6. DATE OF SURVEY **11/12/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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Effective December 29, 2019, due to15 beds being relicensed, the number of licensed and certified beds in your facility are increased from 74 beds to 89 beds in accordance with a change in licensure. After this change they will have zero (0) beds on layaway.

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NE II 12/31/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 01/07/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted from 11/4/19 through 11/12/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/4/19 through 11/12/19, a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5304060C deficiency issued at F689 H5304061C deficiency issued at F689 H5304062C deficiency issued at F689 H5304063C deficiency issued at F689 H5304064C deficiency issued at F755 H5304065C substantiated with an associated tag issued at F689 H5304066C deficiency issued at F689 H5304067C deficiency issued at F689 H5304069C deficiency issued at F744, F609, F610 H5304070C deficiency issued at F689 Complaint H5304068C was found to be unsubstantiated The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are	F 000		

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

Electronically Signed | 12/17/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,	F 561		12/29/19

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

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F 561	Continued From page 2 religious, and community activities that do not interfere with the rights of other residents in the facility. This 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. Findings include: 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	F 561	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual. 1.It is the policy of the facility to ensure resident choices are honored. Resident R46 was interviewed and his care plan was updated to reflect his choices. The Kardex also was updated with R46 preferences. All residents and/or families are interviewed for preferences of care and services upon admission, quarterly, annually and with significant changes as part of the RAI Process. The care plan and Kardex reflect their preferences. 2.All current residents have been reviewed for current preference assessment and reassessed as needed. Care plans reviewed and updated to reflect current preference needs. This has the potential to affect all facility residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 561	Continued From page 3 assistant (NA), "Whose call light is on?" NA told 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 6:29 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 still activated. -At 6:31 p.m. R46 observed sitting in his w/c in	F 561	3.Staff will be in-serviced on resident rights with self-determination and choices on 12/20/2019. 4.The director of nursing or designee will be responsible for compliance. Audits will be completed to ensure resident choices are honored to prevent reoccurrence of this deficiency daily x 4 weeks, weekly x 4 and then monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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F 561	Continued From page 4	F 561		

his room waiting for assistance to bed with call light on.
-At 6:33 p.m. no call lights activated in hall 200
-At 6:33 p.m. R46 observed still waiting in his room to go to bed.
-At 6:38 p.m. R10 and R54's call lights came on over their room doors.
-At 6:40 p.m. R46 wheeled himself out of his room into hallway looking down hallway. RN-A told R46 she could get R46 hooked up to the lift while he was waiting.
-At 6:44 p.m. R46 was observed sitting in his w/c in his room with RN-A present hooked up to the transfer lift.
-At 6:47 p.m. NA walked into R46's room to assist RN-A to transfer R46 to bed. (R46 waited 41 minutes for staff assistance).
-At 7:18 p.m. R46 stated to surveyor he wants to go to bed at 6:00 p.m. every evening. R46 stated he "waits that long all the time to go to bed, it's the usual."

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 bed. NA-B stated residents who needed less care at the last step of the process to bed went to bed first and the residents who required more steps last. NA-B stated there was not enough staff to wash residents up. NA-B stated that was generally the norm here at the facility.

LPN-C stated on 11/6/19, at 2:21 p.m. showers could not be completed when only having two NAs. LPN-C stated last Sunday only had two NAs and generally couple times a pay period ran with only two NAs instead of three NAs. LPN-C stated he cracked down on the NAs for turning off call

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F 561	Continued From page 5 lights before assisting resident. LPN-C stated R46 gets left to the end and staff leave tend to leave him and since R46 is patient R46 pays the price. LPN-C stated usually the DON and nurse manager aren't answering the call lights. R46's careplan dated 11/7/19, did not include R46's preference for bedtime at 6:00 p.m. RN-A nurse manager, stated on 11/7/19, at 2:26 p.m. R46 can go to bed at 6:00 p.m. and all staff knew that. RN-A stated R46's preference for bed time was not identified on R46's NA care sheet "as staff just know by word of mouth." DON stated on 11/7/19, at 2:45 p.m. R46 could go to bed at 6:00 p.m. as it was his preference. DON stated staff should accommodate this and follow residents' careplan. Facility policy Self Determination and Participation dated 7/25/16, indicated residents would be allowed to choose schedules that are consistent with their interest for daily routine including sleeping. The policy indicated to facilitate resident choices staff would gather information about residents' personal preferences upon initial assessment and periodically thereafter, and document these preferences in the medical record. 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.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 565		12/29/19

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	245304	A. BUILDING _____ B. WING _____	C 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

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F 565	Continued From page 6 §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This 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	F 565	1.Resident Council members were invited to meet on 12/13/2019 to address the grievance process. They were informed	

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F 565	Continued From page 7 times for 8 of 9 residents (R1, R3, R12, R51, R18, R22, R24, R37) in Resident Council. Findings include: During resident council meeting on 11/6/19, at 2:08 p.m. R1, R3, R12, R51, R18, R24, R37 stated they waited a long time for their call lights to be answered, up to an hour and longer they waited for staff assistance. R1, R3, R12, R51, R18, R24, R37 stated long call lights had been a problem in the facility since last spring, and was getting worse the last couple of months, and stated nothing had been changed or done to help with the problem. Resident Council (RC) minutes dated 4/24/19, identified residents present at the April meeting expressed call lights were not answered in a timely manner. RC members stated nursing assistants (NA)s turned off the call lights and ignored residents who activated their call lights. April 2019 Grievance reports identified no report was completed for resident council complaints regarding call light concerns. RC minutes dated 5/29/19, identified long call lights not being answered at meals and still being turned off with no assistance provided. A letter dated 5/7/19, responding to RC members did not address concerns with call lights. RC minutes dated 6/26/19, identified call lights not being answered in a timely manner waiting 45 minutes to 1 hour for staff assistance, and staff still turning off call lights without talking to the resident and providing assistance.	F 565	on what the facility is doing to resolves their grievances on 11/13/2019. Ongoing all Resident Council grievances will be address within five working days with the result posted on the resident bulletin board until the next Resident Council meeting 2.All these grievances and any new grievances will be reviewed at the next QAPI meeting on 12/19/2019. 3.Management staff have been in-service on 12/13/2019 on the grievances policy and procedures. Then all remaining staff were in-service by 12/29/2019. 4.The Social Service Director or designee will be responsible for compliance Audits will be completed on grievances to prevent reoccurrence of this deficiency weekly x 4, then monthly x 2.Results will be reviewed by our QAPI committee for further recommendations	

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F 565	Continued From page 8	F 565		

RC minutes dated 7/31/19, identified residents were frustrated over no resolution to the same call light concerns and nothing being done about them.

RC minutes dated 8/28/19, did not note anything regarding call lights or staffing.

RC minutes dated 9/25/19, did not note anything regarding call lights or staffing.

RC minutes dated 10/10/19, identified there had been no follow up done for long call light wait times and staff behaviors.

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.

During interview with administrator on 11/12/19, at 2:28 p.m. he stated he did not read the monthly RC minutes and stated each department head was responsible for follow up with concerns from residents at the monthly meetings. Administrator stated no call light audits had been completed regarding residents' concerns with long call light wait time 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.

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F 565	Continued From page 9 Grievance policy dated 10/10/19, indicated the facility encouraged all residents to utilize the Resident Council as an opportunity to meet with other residents to discuss any area of concern. The policy indicated residents' concerns would be addressed in a satisfactory and timely manner.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		12/29/19

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F 578	Continued From page 10 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an accurate record was updated to include appropriate code status (a resident's wishes for life-saving emergency treatment) regarding cardio pulmonary resuscitation (CPR) for 1 of 12 residents (R42) reviewed for Advance Directives. Findings include: R42's EMR (electronic medical record) was accessed on 11/04/19. R42's EMR identified he was full-code status (indication to initiate CPR). R42's physician orders dated 10/31/19, identified R42 had full code status. R42's 5/23/19, Physician Order for Life Sustaining Treatment (POLST) identified R42's code status was DNR/DNI (do not resuscitate/do not intubate). The POLST form was signed by registered nurse (RN)-A and R42's physician, and was the most recent POLST in R42's EMR. R42's signature was not written on the document. Interview on 11/5/19, at 1:42 p.m. with licensed	F 578	1.The facility recognizes the resident□s right under state law to make decisions concerning medical care, including the right to accept or refuse medical treatment, and the right to formulate Advance Directives. The facility agrees to honor decisions concerning medical care, including the right to accept and refuse treatment, when made in accordance with state law. R42 had code status verified to ensure accuracy by the nurse practitioner. The POLST, physician orders and care plan were verified and updated. All resident charts were audited to ensure code status forms were complete and corresponded with MD orders. Care Plans were reviewed and updated as needed. 2.All current residents have been reviewed for current POLST and updated as needed. Care plans reviewed and updated to reflect current POLST request. This has the potential to affect all facility residents 3.Nursing staff, and social services has been in-serviced on the Facility Guidelines for Code Status and Advance Directives	

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F 578	Continued From page 11 practical nurse (LPN)-D identified R42's EMR indicated R42 had full code status. LPN-D stated if R42 arrested, the quickest way to identify code status was to look in R42's EMR. If the code status was not identified in R42's EMR, LPN-D stated she used the most recent POLST in the EMR scanned documents. During interview on 11/5/19, at 1:54 p.m. R42 stated he wanted to be resuscitated if he stops breathing and his heart stops. R54's EMR was reviewed again on 11/5/19. The EMR identified R42's code was DNR/DNI. During interview on 11/5/19, at 4:10 p.m. with RN-A verified she was unsure why R42 had a POLST indicating he was DNR/DNI in the chart, and agreed it could cause R42 to receive the incorrect resuscitation measures if he had cardiopulmonary arrest. The director of nursing (DON) was interviewed on 11/5/19, at 4:14 p.m. and stated she expected the staff to follow the POLST to ensure appropriate resuscitative measures were implemented according to resident and family choices. DON verified R42 continued to choose to maintain full-code status. DON confirmed she had just changed R42's code status to DNR in his electronic medical record after reviewing his 5/23/19, POLST. R42 was his own responsible party and was re-interviewed, and chose to remain full code, so his code status was going to be changed back to full-code in the EMR. DON agreed staff had the potential to deliver the incorrect resuscitative measures with conflicting POLST and EMR documentation.	F 578	4.The director of nursing or designee will be responsible for compliance. Audits will be completed to ensure resident code status and POLST are accurate and documented correctly in the electronic medical record weekly x 4 and then monthly x 2. Results will be reviewed by our Quality committee for further recommendation.	

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F 578	Continued From page 12	F 578		

During interview on 11/5/19, at 4:21 p.m. RN-B stated she was the staff development (SD) coordinator, and was responsible for staff training and orientation. She instructed new licensed staff about the crash cart and where to identify code status. SD stated she expected staff to use the most recent POLST rather than information from the EMR because the POLST was the most accurate and current document identifying a resident's code status. She had worked in her role for about a year, and was unsure how or who was responsible for educating existing licensed staff about the facility's crash cart, and the facility's code status policies and procedures. RN-B was not familiar with the facility's code status policies and procedures, which were not reviewed with staff on a routine basis. Additionally, RN-B verified she had no documentation code status education was provided for new facility and agency staff upon hire.

On 11/5/19, at 4:28 p.m. the social worker (SW) -A indicated residents were encouraged to complete advanced directives upon admission. A POLST was provided and reviewed with new residents to establish code status and health care directives upon admission. Code status was reviewed quarterly, and on an as-needed basis, with significant changes in status, and after hospitalization. The nurse managers (NM) were responsible for updating and ensuring accuracy of each resident's code status. NM were also responsible to ensure the resident and/or guardian decisions were documented with all necessary signatures, included on the POLST, updated and accurate in the residents EMR, care plan and physician orders. SW-A was unsure of any additional processes in place to ensure

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F 578	Continued From page 13	F 578		

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 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. If a resident had questions, staff referred a resident to the resident's family, physician, and outside resources. The policy did not direct staff to a specific document in the event of code status discrepancies, and did not identify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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

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F 578	Continued From page 14 a process to ensure accuracy of resident code status. The Emergency Procedure-Cardiopulmonary Resuscitation policy and procedure dated 8/3/16, indicated the procedure for administering CPR incorporated the steps in the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency 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.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		12/29/19

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F 584	Continued From page 15 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow up on a report of a missing ring for 1 of 2 residents (R25) reviewed for missing personal property. Findings include: R254's Minimum Data Set (MDS) dated 9/30/19, indicated R254 was admitted on 9/26/19, from the hospital with diagnoses that included alcoholic hepatitis and withdrawal, depression, and muscle weakness after falling at home and hitting his head. The MDS indicated R254 was cognitively intact. R254 was interviewed on 11/4/19, at 1:54 p.m. and stated he was there for physical therapy to	F 584	1.R25 discharge from this facility on 11/12/2019 when he got home he found the ring in a drawer that he had reported to surveyors to have lost. Staff failed to report R25 concern on a grievance/concern form to alert staff of missing ring and to investigate his concern. 2.All these grievances and any new grievances will be reviewed at the next QAPI meeting on 12/19/2019. 3.Management staff have been in-service on 12/13/2019 on the grievances policy and procedures. Then all remaining staff were in-service by 12/29/2019. 4.The Social Service Director or designee will be responsible for compliance. Audits	

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F 584	Continued From page 16 increase strength with a plan to discharge to home. During an interview on 11/4/19, at 4:30 p.m. R254 indicated he was missing a ring from the top drawer of the nightstand next to the bed. R254 stated the ring had been in a sandwich-sized plastic baggie and noticed it was missing in mid October. R254 described the ring as gold with an amethyst center stone missing. R254 stated the ring had been his father's wedding ring from 1945 and the stone was both his father's and his birthstone. R254 estimated the cost of the ring to be $200. R254 indicated the ring was mostly of sentimental value. R254 stated the missing ring was reported to the Director of Social Services (DSS) when he noticed it was missing but was told there was nothing that could be done. R254 also stated he did not know if it was stolen. DSS was interviewed on 11/7/19, at 2:24 p.m. and verified R254 reported the missing ring to her but stated there was no investigation initiated because the ring was not included in R254's personal property inventory completed on admission. DSS indicated she was not able to retrieve the inventory in R254's medical record, but thought it just hadn't been scanned in. DSS requested a copy from medical records. Staff were told to keep their eyes open for it. Additionally, she confirmed she was not aware of the value or if R254 thought it was stolen. LPN-G and LPN- H were interviewed on 11/7/19, at 2:32 p.m. and neither were not aware of a missing ring. 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	F 584	will be completed on grievances to prevent reoccurrence of this deficiency weekly x 4, then monthly x 2. Results will be reviewed by our QAPI committee for further recommendations	

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F 584	Continued From page 17	F 584		

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 made for any item valued at $50 or greater. R254 was confused when admitted and the

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 584	Continued From page 18 administrator indicated the family should have been contacted to verify the item was missing. The administrator also stated he was confident no one had seen the ring and the facility did not usually contact hospitals to see if the item was sent with the resident. The administrator indicated DSS should have taken a few more steps. DSS was interviewed again on 11/12/19, at 10:26 a.m. and verified the the family had not been contacted. The DSS was not able to produce the personal property inventory. The facility Grievance Policy dated 10/10/2019, outlined that missing article grievances are directed to the DSS and the follow up process included investigation of specific details surrounding the issue of concern, with the goal of addressing and resolving the concerns.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency	F 609		12/29/19

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F 609	Continued From page 19 and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report timely an allegation of mistreatment to the State Agency (SA) for 1 of 5 residents (R41) reviewed for 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 like ...was 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 reported to the SA. DON indicated LPN-A and/or R41 or other staff were not interviewed at that time. DON, the assistant director of nursing (ADON) and NA-B were interviewed on 11/5/19, at 5:06 p.m. and NA-B stated on 11/2/19, it was reported to ADON that a few evenings ago NA-B observed	F 609	1.It is the policy of this facility to ensure that all residents are free from abuse, neglect, misappropriation of resident property, and exploitation. R41was reviewed to ensure they were free from any abuse. The allegation of abuse was reported to OHFC and an in-depth investigation was completed. 2.This has the potential to affect all facility residents. All current residents have been assessed to ensure they are free from abuse, neglect, misappropriation of resident property, and exploitation. 3.Staff have been in-serviced on the facility abuse policy on 12/20/2019. 4.The director of nursing or designee will be responsible for compliance. Audits will be completed on all risk management and grievances to ensure no abuse, neglect, misappropriation of resident property and exploitation of residents has occurred to prevent reoccurrence of this deficiency daily x 4 weeks, weekly x 4 and then monthly x 1. Results will be reviewed by our Quality committee for further	

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F 609	Continued From page 20	F 609		

LPN-A "being physical" and "rough" with R41. NA-B explained R41 was asking not to be touched and LPN-A continued on and "man handled" R41 as R41 was "begging not to touch" her. NA-B stated R41 repeatedly yelled, "leave me alone leave me alone" as R41 tightened her arms inward, however LPN-A did not stop. NA-B indicated LPN-A asked NA-D to assist with changing R41 out of urine soaked clothing and both LPN-A and NA-D continued "manhandling" R41 while "pulling her clothes off against her will." ADON confirmed that 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 it was not reportable. NA-B stated he did not report the concern of rough treatment to R41 right away due to having been a newer staff at the facility and worried about retaliation from LPN-A.

DON was interviewed on 11/6/19, at 10:35 a.m. and verified a report regarding an allegation of physical abuse was submitted to the SA on 11/5/19. DON stated it was their expectation to report any allegation of abuse to the administrator and/or SA within two hours.

R41 was interviewed on 11/7/19, at 6:49 a.m. and was unable to answer questions.

R41's Quarterly Minimum Data Set (MDS) dated 8/26/19, identified R41 had severe cognitive impairment and diagnoses which included dementia and Parkinson's disease. The Quarterly MDS indicated R41 required extensive staff assistance with activities of daily living.

The facility Abuse Policy and Procedure adopted 9/27/19, indicated abuse referred to mistreatment

recommendation.

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F 609	Continued From page 21 or infliction of harm by someone to an individual. The policy indicated residents had the right to be free from abuse and the facility would not condone any form of resident abuse. The policy indicated any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the administrator, DON or change nurse and when an incident of resident abuse was suspected or confirmed the incident must have been reported to facility management regardless of the time lapse. The policy further indicated the facility would report suspected or identified abuse in a timely manner to appropriate agencies.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 610	1.There was an allegation of abuse	12/29/19

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F 610	Continued From page 22 review, the facility failed to thoroughly investigate and provide protection following an allegation of staff mistreatment for 1 of 5 residents (R41) reviewed for 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 like ...was 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. DON, assistant director of nursing (ADON) and NA-B were interviewed on 11/5/19, at 5:06 p.m. NA-B stated on 11/2/19, it was reported to ADON that a few evenings ago NA-B observed LPN-A "being physical" and "rough" with R41. NA-B explained R41 was asking not to be touched and LPN-A continued on and "man handled" R41 as R41 was "begging not to touch" her. NA-B stated R41 repeatedly yelled "leave me alone leave me alone" as R41 tightened her arms inward, however NA-B indicated LPN-A did not stop. NA-B indicated LPN-A asked NA-D to assist with changing R41 out of urine soaked clothing and both LPN-A and NA-D continued "manhandling"	F 610	involving R41was communicated to administrative staff on 11/05/2019. It was reported to OHFC and an in-depth investigation followed that included placing two staff members on investigatory leave and interviewing many staff members that worked with the alleged perpetrators. 2.The facility will take the following actions in response to an alleged violation of abuse, neglect, exploitation or mistreatment: Thoroughly investigate the alleged violation that will include placed the alleged perpetrator on investigatory leave, complete a through body audit of the resident involved. The body audits may expand to residents in the facility that have dementia. Residents that are alert and oriented will be interviewed regarding their interactions with the alleged perpetrator. The resident involved will have cares observed. Staff will be interviewed to see if they have concerns, they will be asked to provide a written statement. Prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress; and take appropriate corrective action, as a result of investigation 3.All staff have been in serviced on the facility policy on investigating any allegation of abuse, neglect, mistreatment, injury of unknown origin and misappropriation of resident property on 12/20/2019 4.The Social service director or designee will be responsible for compliance. Audits will be completed on all OHFC reports to ensure a thorough investigation was	

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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. DON was interviewed on 11/6/19, at 10:35 a.m. and verified the facility began investigating an allegation of physical abuse and both LPN-A and NA-D were placed on administrative leave. DON stated it was their expectation to begin investigating and observing cares/ monitoring the unit following an allegation of physical abuse. R41 was interviewed on 11/7/19, at 6:49 a.m. and was unable to answer questions. R41's Quarterly Minimum Data Set (MDS) dated 8/26/19, identified R41 had severe cognitive impairment and diagnoses which included dementia and Parkinson's disease. The Quarterly MDS indicated R41 required extensive staff assistance with activities of daily living. The facility Abuse Policy and Procedure adopted 9/27/19, indicated abuse referred to mistreatment or infliction of harm by someone to an individual. The policy indicated residents had the right to be free from abuse and the facility would not condone any form of resident abuse. The policy indicated any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the administrator, DON or change nurse and when an incident of resident abuse was suspected or confirmed the incident must have been reported to facility management regardless of the time lapse. The policy indicates when an incident of suspected resident abuse or mistreatment was reported the facility would initiate a report to the	F 610	completed to prevent reoccurrence of this deficiency daily x 4 weeks, weekly x 4, then monthly x 1. Results will be reviewed by our Quality committee for further recommendation	

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F 610	Continued From page 24 SA and begin investigation of the alleged incident which would include witness reports, staff interviews and interview other residents. Furthermore, the policy indicated employees of the facility whom had been accused of resident abuse would be suspended immediately pending outcome of the investigation.	F 610		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 676		12/29/19

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 25 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and ensure the necessary cares and services were developed regarding bladder incontinence for 1 of 1 resident (R35) who was able to carry out some of her ADL activities. Findings include: R35 was observed on 11/7/19, at 7:10 a.m. with her call light on. At 7:19 a.m. nursing assistant (NA)-C entered R35's room. R35 was observed to be lying in bed with a strong urine odor coming from R35's bed. R35 requested to go to the bathroom as NA-C removed R35's blanket NA-C indicated R35 was lying in a urine soaked bed. NA-C indicated R35's "entire bed was "wet" from urine and needed to be changed. NA-C assisted R35 to turn onto her side and indicated R35 was wet with urine from the middle of the thighs up to the middle of the back. NA-C indicated the urine was dried to the bedding around the edges and the bedding was cold and wet. R35 was interviewed on 11/7/19, at 7:35 a.m. and stated she had asked to go to the bathroom around midnight, however indicated the staff whom answered her call light turned her call light off and did not respond and walked out of the	F 676	1.R35 will have a bowel and bladder assessment to identify toileting patterns. This will be completed by 12/29/2019. An analysis of the bowel and bladder assessment will be done and a toileting program will be scheduled. 2.All current residents have been reviewed for current bowel and bladder assessment and reassessed as needed. Care plans reviewed and updated to reflect current bowel and bladder needs. This has the potential to affect all facility residents 3.All nursing staff have been in serviced on the facility policy for bowel and bladder assessments by 12/29/2019. All nursing staff will be in serviced on providing necessary care and services. 4.The director of nursing or designee will be responsible for compliance. Audits will be done weekly x 4 and then monthly x 2. Results will be reviewed by our Quality committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 26	F 676		

room. R35 stated she went back to sleep and indicated it "only happens sometimes" when staff would not assist R35 to the bathroom.

NA-C was interviewed on 11/7/19, at 7:40 a.m. and stated there were certain days of the week when residents would be found in bed that were wet, however indicated wet beds was not uncommon.

R35 was observed on 11/7/19, at 8:31 a.m. and told the administration during breakfast that she had an accident during the night. R35 indicated "she was soaking wet" and staff should have been on the schedule to help people "so that they don't lay in bed soaking wet."

R35's annual Minimum Data Set (MDS) dated 9/26/19, indicated R35 had moderate cognitive impairment and diagnoses which included manic depression and diabetes mellitus. The annual MDS indicated R35 required extensive assistance with ADLs and did not have a toileting program. The MDS further indicated R35 was occasionally incontinent or urine and bowel.

R35's care plan revised 10/2/19, identified R35 had a self-care performance deficit and directed staff to assist for toileting, occasional incontinent of bladder, change when soiled and as needed. R35's care plan revised 10/10/19, identified R35 had occasional bowel and bladder incontinence related to need for staff assistance with toileting tasks and use of medications and directed staff to change as needed when soiled, pericare with each incontinent episode and monitor for signs and symptoms of urinary tract infection.

R35's Urinary Incontinence Care Area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 27	F 676		

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 "entire 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 toileting, prompted voiding or other interventions to try to manage incontinence. The policy further indicated incontinence care should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 28 individualized at night in order to maintain comfort and skin integrity and minimize sleep disruption.	F 676		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This 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 2 residents (R29, R42) who needed assistance with grooming. Findings include: R44 was observed on 11/8/19, at 7:40 a.m. with his call light on. At 7:59 a.m. R44 indicated he had been on the bed pan waiting for "30 to 45 minutes" and needed assistance to get off of the bed pan as he had "been done for a long time." At 8:05 a.m. nursing assistant (NA)-A was observed to answer R44's call light when entering R44's room R44 told to NA-A he had been "waiting more than I should." R44 was observed to have had a bowel movement NA-A provided pericares and assisted R44 off of the bed pan. R44 also said to NA-A that he had been waiting "45 minutes" and NA-A replied, "we are working as fast as the two of us can." R44's quarterly Minimum Data Set (MDS) dated	F 677	1.The facility is committed to having residents participate in activities of daily living (ADLs) to their fullest ability and provide cares for residents that are not able to do their ADLs. R43, R44 and R42□s assessments and care plan related to ADLs will be reviewed and completed by 12/29/2019. R29 is deceased. All residents and/or families are interviewed for preferences of care and services upon admission, quarterly, annually, with significant change and as needed as part of the RAI Process. The care plan and Kardex reflect their preferences. Level of assistance required, and bathing preferences will be communicated to direct care staff through PCC and POC. Preferences and level of assistance will be reviewed quarterly at care conferences and as needed. 2.All current residents have been reviewed for current ADL assessment and 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 nursing	12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 29 10/7/19, identified R44 had intact cognition and diagnoses which included dementia and manic depression. The quarterly MDS indicated R44 required extensive assist with toileting and was frequent incontinent of bowel without a toileting program. R44's care plan revised on 10/22/19, indicated R44 had an ADL self-care performance deficit and directed staff to provide extensive assistance of staff for the use of the bed pan for bowel movements. R44 was interviewed on 11/8/19, at 8:15 a.m. and stated staff when staff would call in he would wait a long time for assistance from staff after activating his call light. NA-A was interviewed on 11/8/19, at 8:20 a.m. and confirmed R44 was waiting at least 30 minutes on the bedpan. NA-A stated they were "really far behind" getting residents up for the day. The director of nursing (DON) was interviewed on 11/8/19, at 1:06 p.m. and stated she expected staff to respond as promptly as they were able. The facility policy regarding toileting was requested, but not provided. 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.	F 677	staff by 12/29/2019, related to resident care expectations. 4.The director of nursing or designee will be responsible for compliance. Audits will be done weekly x 4 then monthly x 2. Results will be reviewed by our Quality committee for further recommendation.	

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

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F 677	Continued From page 30	F 677		

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 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 report indicated bathing "Not Applicable;"
-On 9/29/19, the report indicated bathing "Not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 31	F 677		

Applicable;"
-On 10/13/19, the report indicated bathing "Not Applicable;"
-On 10/27/19, the report indicated independent with bathing;
-On 10/31/19, the report indicated bathing "Not Applicable;"
-On 11/7/19, (after survey began), the report indicated extensive assist with bathing.

R43 was interviewed on 11/6/19, at 8:32 a.m. and stated he "wants a shower." R43 was observed to have approximately quarter inch long finger nails with brown dirt underneath the nail, dirty clothing with food stains on them, and R43 was malodorous. R43 stated he had not had a shower in over two weeks and when he had requested no staff would come back to assist him.

NA-B was interviewed on 11/5/19, at 2:32 p.m. and verified R43 had not had a shower for three weeks.

NA-C was interviewed on 11/6/19, at 8:41 a.m. and confirmed R43 had not had a shower lately. NA-C explained at times residents would miss their scheduled shower and the shower would be moved to the next day and/ or the next day. NA-C stated showers were documented in the electronic medical record when completed.

DON was interviewed on 11/8/19, at 12:07 p.m. and stated it was her expectation for R43 to be showered per the shower schedule which was weekly. DON stated she expected a male staff to shower R43 per request and confirmed R43 had not been showered in the past two weeks. However, DON stated R43 did receive a shower last evening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 32	F 677		

A facility policy regarding bathing was requested, but not provided.

R29's 8/29/19, quarterly MDS identified R29 had severe cognitive impairment. R29 required extensive assistance of one staff to dress and perform personal hygiene. R29's diagnoses included Alzheimer's disease, dementia with behaviors, weakness, degenerative joint disease, dystonia (uncontrolled movement), and history of dehydration.

R29's care plan identified R29 had dementia with cognitive loss, limited physical mobility, and weakness. R29 was unable to provide self-care. He required extensive assistance of 1 staff to dress and perform personal hygiene. R29 was unable to communicate needs. Staff were to anticipate and meet R29's needs. R29 had aggressive behavior with cares. R29 had a recent diagnosis of dehydration. Staff were to supervise and assist R29 with meals, encourage fluid intake, and provide a nosey cup for fluid intake. R2 was at risk for aspiration and had problems coughing and choking while eating and drinking. R29 was not to use straws.

R29's undated, current NA care sheet included R29 required extensive assistance of two staff to perform personal hygiene. R29 was to eat only with supervision. R29 ate in the small dining room to ensure staff could observe him at all times during meals. Staff were to offer fluids throughout the day and use a nosey cup for liquids.

Observation on 11/4/19, of R29 at 10:37 a.m. identified R29 appeared unshaven, and debris under his fingernails.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 33	F 677		

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.

Interview on 11/7/19, at 1:15 p.m. with LPN-E stated he was unaware R29 was not supposed to drink with a straw. LPN-E acknowledged he had not looked at R29's care plan prior to providing R29 a straw to drink the supplement. LPN-E checked R20's electronic medication administration and verified it did not indicated R29 was not to drink with a straw.

Interview on 11/07/19, at 2:54 p.m. with DON identified she was aware of R29's unkempt unshaven face. Staff reported they attempted to shave him but his razor blades were dull. Two weeks ago, DON contacted R29's guardian to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 34	F 677		

purchase new razor blades. R29's guardian was new, and unable to access R29's money to purchase new blades until recently. The facility had no razor blades for R29 to use in the meantime. DON stated staff were to use nosey cups for R29 and provide supervision with meals and fluid intake. The care plan stated no straws. DON expected staff to follow R29's care plan.

Interview on 11/08/19, at 11:49 a.m. speech therapist (ST)-A verified R29 required assistance and supervision to eat and drink. ST-A instructed staff to not use straws because R29 was not swallowing well following a recent change in condition and was at risk for silent aspiration where fluids had the potential to enter his airway and lungs. The only way to diagnose silent aspiration was by performing a video swallow study. R29 was to undergo testing, however that had been canceled due to R29's admission to hospice. ST-A was unable to verify if straw use was appropriate without a video swallow study. As a precaution, had not recommended R29 to use a straw.

R42's 9/30/19, quarterly MDS identified his cognition was intact. R42 had minimal signs of depression, but felt tired and had little energy several days per week. R42 had hallucinations and no behaviors. R42's functional status needs included extensive assistance of 2 staff to transfer. R42 required extensive assistance of 1 staff for bed mobility, locomotion on and off the unit, and with personal hygiene.

An observation and interview with R42 on 11/04/19, at 3:41 p.m. identified R42 was lying in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 35	F 677		

bed. R42's bed was at floor level. R42's bed and clothing had crumbs on it. He was wearing oxygen. R42's facial hair was ½ inch long, and covered his face. R42 was not growing a beard and was unable to shave because the electric razor he had recently purchased was missing. R42 was "fed up with how they do things around here because they [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 asking for it. R42 required assistance to shave, bathe, use the bathroom and perform daily care. R42 also required assistance with ambulation in his wheelchair as he tired easily. On several occasions R42 asked for assistance to get back to his room. Staff told R42 could push himself and frequently refused to help him back to his room. R42 frequently waited for over one-half hour for assistance when he activated his call light to get help.

Observations from 11/04/19, at 6:41 p.m. through 11/07/19, at 7:41 a.m. identified R42 continued to be unshaven.

Observation and interview on 11/07/19, at 12:42 p.m. NA-C stated staff periodically check R42's liquid oxygen canister to make sure it was on. She was unsure if he needed oxygen at all times, but usually saw him wearing it. NA-C had not assisted R42 to his room after lunch, and was unsure if any other staff assisted him to his room. R42 was able to pedal himself in the hallways from the dining room, and was unsure if he required help to get to and from the dining room.

Interview on 11/07/19, at 2:44 p.m. with DON identified she had asked staff to shave R42 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 36 the past 2 days. DON was aware R42 reported his razor was missing, but did not complete a grievance because he was a hoarder, and his razor was not missing. DON stated was not sure what was wrong with R42, because he was never like this. DON verified she had requested staff to assist R42 to shave on Tuesday, and she would have staff find his razor and assist him to shave today. At 3:20 p.m. DON reported staff found his new razor in his bucket in his room on the night stand. DON verified staff had not looked for the razor and had not shaven R42 after she requested them to, but they were assisting him now. A policy and procedure was requested for quality of care or providing activities of daily living. No policy was provided.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide person centered, meaningful activities which included activities outside of the facility for 1 of 3 residents	F 679	1.The facility is committed to ensuring all residents have meaningful activities to participate in. R43 interest in activities was reviewed by the activity director to	12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 37 (R43) reviewed for activities. Findings include: R43 was interviewed on 11/4/19, at 6:55 p.m. and stated he was unable to attend the monthly shopping activity due to the facility scheduling the outings outside of the facility on Wednesdays which conflicted with R43's dialysis schedule. R43 indicated it was important for him to go person item shopping for himself due to having been a younger man and not wanting staff and/or his mother always doing his personal item shopping. R43 stated he spoke to the director of nursing (DON) and the activities director (AD) about his desire to participate in a shopping activity, however no changes and/ or follow-up occurred. R43's annual Minimum Data Set (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 it was "very important" for R43 to do his favorite activities. R43's care plan revised on 10/23/19, identified R43 had little time in the facility to participate in activities and directed staff to explain to R43 the importance of social interaction, leisure activity time, participation in activities, invite/ encourage R43's family to attend activities with R43 to support participation, offer a variety of activity types and locations to maintain interests, modify daily schedule and treatment plan to accommodate activity participation as requested by R43.	F 679	ensure we were meeting the needs of 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 by 12/29/2019. 3.The activity director and activity staff were in serviced on 12/18/2019 on the facility policy of meaningful activities for residents. 4.The activity director or designee will audit to ensure all residents are participating in meaningful activities to ensure compliance. Audits will be completed weekly x 4 then monthly x 2. Results will be reviewed by our Quality committee for further recommendations.	

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

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F 679	Continued From page 38	F 679		

R43's Activity Participation Review effective 10/2/19, indicated R43's attendance preferences and participation level with activities was left blank, no interventions and/ or adaptations needed for R43 to participate in programs, care plan remained current and appropriate, goals were met and interventions remained effective.

R43's Activity Schedule was reviewed from 8/2019, through 10/31/19, and revealed the following:
-R43's 8/2019, schedule indicated R43 participated in going outdoors, watching TV and/or movies and physical games/activity daily, however lacked evidence of facility outing;
-R43's 9/2019, schedule indicated R43 participated in one facility outing on 9/19/19, and daily going outdoors and physical games/ activity;
-R43's 10/2019, schedule indicated R43 participated in going outdoors daily and physical games/activity, however lacked evidence of facility outing, however lacked evidence of facility outing.

AD was interviewed on 11/8/19, at 10:03 a.m. and verified R43 had not participated in an activity outside of the facility since 9/2019, when he went for a senior golf cart ride and in 7/2019, when he attended a baseball game. AD stated R43 enjoyed going outside daily to smoke on the front patio and visit with peers. AD confirmed the facility offered shopping activities on Wednesdays, however R43 was unable to attend due to R43's dialysis schedule. AD stated she was aware R43 "mentioned" he wanted to out of the facility shopping and/or to activities outside of the facility, however AD stated Wednesdays worked best for the activities department due to their staffing. AD explained she had not

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

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F 679	Continued From page 39 attempted to offer an alternate day for activities outside of the facility, however identified Thursdays staffing would be able to accommodate this. DON was interviewed on 11/8/19, at 12:11 p.m. and stated it was her expectation for the facility to try their best to make accommodations so all residents were able to participate in activities. DON explained R43 was able to attend an activity outside of the facility over the summer, however R43's dialysis had to be rearranged to ensure R43 could attend. The facility activity policy was requested, but not provided.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promptly respond to 1 of 1 resident (R44) report of shortness of breath, chest pain, and request to be transported to an Emergency Room for evaluation. In addition, the facility failed to perform leg treatments for 1 of 1 resident (R7) scheduled for daily leg wraps for lymphedema.	F 684	1.The facility is committed to caring for residents in a competent and dignified manner to include honoring requests and choices related to their care. R44 was transferred to the emergency department on 11/07/2019 at 12:57 p.m. after complaining of chest pain, shortness of breath and wheezing. He returned a few	12/29/19

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	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40 Findings include: R44's Diagnoses Report printed on 11/7/19, included diagnoses of sepsis, pneumonia, hypoxemia, and urinary tract infection (UTI) on 10/29/19. R44 also had diagnoses of bipolar disorder, Major Depression Disorder, anxiety disorder, restlessness and agitation, dementia with behavioral disturbance, obesity, neuropathy, lower back pain and neuropathy of the lower extremities, pancreatic and splenic cysts, and a history of pulmonary embolism, lower extremity deep vein thrombosis, and UTIs. R44's quarterly Minimum Data Sheet (MDS) on 10/7/19, identified R44's cognition was intact, had moderate depression, was delusional and verbally aggressive towards others, and rejected care on a daily basis. R44 required extensive assistance of one staff for bed mobility, He required extensive assistance of two staff to transfer and toilet and required supervision and setup for eating. R44 had pain rated 5/10 frequently and received scheduled pain medications. R44 had severe obesity and was five feet seven inches tall and weighed 272 pounds. R44 used antipsychotic, antidepressant, and diuretic medications. R44's care plan identified R44 required assistance of two staff to turn and reposition in bed. R44 used a full body lift and assistance of two staff to transfer. R44 required supervision during meals and sat in the assisted dining room. R44 had verbally abusive behaviors, was demanding, refused cares, and had ineffective coping skills. Staff anticipated needs, explained cares, allowed time to process information. R44	F 684	hours later with no new orders. On 11/26/2019, R44 was transferred to Mayo Clinic St. Mary□s Hospital and had an extensive workup. He returned on 12/3/2019. R44 signed onto hospice on 12/12/2019. R7 was interviewed on preferences related to application of compression devices. The treatment was scheduled based on resident preference. All resident□s will be interviewed by 12/29/2019 to ensure a person-centered approach is in place and choices are honored. 2.This has the potential to affect all facility residents 3.Education will be provided to all nurses prior to 12/29/2019 related to Change in Resident□s Condition or Status policy, Accommodation of Needs policy and the Self Determination and Participation policy. 4.The director of nursing or designee will be responsible for compliance. Audits will be completed daily x 4 weeks then monthly x 2. Results will be reviewed by our Quality committee for further recommendation	

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	245304	A. BUILDING _____ B. WING _____	C 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

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F 684	Continued From page 41	F 684		

had impaired thought processes. Interventions were to keep consistent routines and caregivers as much as possible, and provide R44 with as many choices as possible. The care plan did not include interventions to address recent hospitalization for pneumonia, UTI and sepsis, and interventions were not included for continued use of antibiotic treatment.

On 10/29/19, R44's hospital discharge note identified on 10/26/19, R44 was admitted to the hospital through the ED for hypoxemia and was diagnosed with pneumonia. Later the same day his temperature spiked and blood cultures were obtained. A urine culture identified a UTI, and R44 received IV antibiotics. The physician orders on 10/29/19, included Augmentin 875-125 mg 1 tablet 2 times daily for 10 days; and Levaquin 750 mg orally in the morning for pneumonia for 9 days.

R44's electronic mediation administration record (EMAR) included nursing orders to assist R44 as needed with cares, and monitor vital signs with oxygen saturation, lung sounds, pain, behaviors, and therapy participation. The order was discontinued on 11/6/19.

During interview on 11/7/19, at 7:43 a.m. the licensed practical nurse (LPN)-B stated she worked the night shift. She was completing her documentation from the night shift she had a resident fall, and the night was very hectic. R44 used the call light over 20 times during the shift. Throughout the night he was anxious, and complained of shortness of breath and chest pain. Staff continued to reposition and attempted to keep him comfortable. R44 refused to elevate the head of the bed and requested to use oxygen.

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

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F 684	Continued From page 42	F 684		

R44's oxygen saturation was 94%. LPN-B told R44 oxygen was not an option because his oxygen level was normal, and starting oxygen could be detrimental. She told him she observed no visible signs of respiratory distress and reassured him he was ok. R44's lungs were wheezy, but had been since retuning from the hospital, and currently received antibiotics. LPN-B did not contact the physician or the DON because he frequently complained of shortness of breath, chest pain, and had requested to go the hospital. His vital signs were normal. She repositioned him and his oxygen saturation was within normal limits. She passed R44's concerns onto the oncoming nurse during change of shift report.

During observation on 11/7/19 a 8:31 a.m. R44 was seated in the dining room eating breakfast. Social worker (SW)-A was visiting with him. He stated good morning, and good bye, he stated he was fine, and declined to be interviewed. R44 had no signs of shortness of breath, and had not signs of anxiety.

On 11/7/19, at 12:15 p.m., an unidentified resident was observed being transported on a gurney out of the 200 wing by an ambulance crew.

On 11/7/19, at 12:57 p.m. LPN-D identified R44 was transported to the emergency department (ED) at 12:57 p.m. following complaints of chest pain, shortness of breath and wheezy lung sounds. He requested to go to the ED. His oxygen was at 94%. He complained of chest pain during the night. When he woke up the morning, he went to the dining room and did not complain of any symptoms. During breakfast, he stated he was not feeling well but wanted to finish

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	245304	A. BUILDING _____ B. WING _____	C 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

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F 684	Continued From page 43	F 684		

eating. After breakfast, staff laid him down, and toileted him. His his vital signs were checked. He was given a nebulizer treatment at 10:48 a.m. which was ineffective. She notified the DON, and he was transferred to the ED to further evaluate his symptoms. He had complained of all of these symptoms through the current course of his illness, and was taking Levaquin and Augmentin 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 on 11/5/19 at 3:05 p.m..

Review of R44's progress notes on 11/6/19 and 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-D identified R44 returned from the ED yesterday, 11/7/19 after a few hours. He had no new issues, and no new orders.

On 11/8/19, at 1:53 p.m. the director of nursing (DON) was notified of R44's change in condition and instructed LPN-D to send him the ER. DON was not aware R44 had chest pain, anxiety, and shortness of breath during the night. She expected staff to contact her and initiate transfer the hospital as soon possible if residents have chest pain and shortness of breath. R44 was seen by MD Tuesday 11/5/19, for wheezing and increased his nebulizer treatments. R44 had a history of shortness of breath and had gastric bypass. Since his admission in January, his weight had increased from 171-200+ pounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 44	F 684		

The physician was worried about aspiration pneumonia along with the weigh gain and shortness of breath. Staff normally called the DON when he had issues. She expected staff to call her and the physician any time changes in health status occur if a nurse had any questions or concerns regarding a resident's condition.

The ED visit report from 11/7/19, was requested on 11/8/19, at 2:00 p.m. following an interview with the DON, and not received for review.

The facility's Change in a Resident's Condition or Status policy (no date), indicated the nurse supervisor or charge nurse was to notify the resident's attending physician of changes including a change in condition when there has been a significant change in the resident's physical/emotional/mental status and if there was 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.

R7 was observed on 11/4/19, at 6:55 p.m. sitting in his wheelchair (w/c) near front desk. R7 stated he had to wait for help in the mornings to get his legs wrapped and get washed up. R7 stated night staff transferred him to his w/c at about 5 a.m.. R7 stated he asked the night nurse to wrap his legs at this time but the night nurse had told him she could not as she was too busy and the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 45	F 684		

nurse needed to wrap his legs. R7 stated he wanted his legs wrapped when he got up because his physician had told him it was better for his leg wound for his legs to be wrapped when getting up and the wound would heal faster.

R7's Annual MDS dated 8/1/19, indicated R7's cognition was intact and included a diagnosis of diabetes and anxiety. R7's Annual MDS indicated R7 needed extensive staff assistance with dressing and with all activities of daily living. R7's MDS indicated R7 did not reject cares.

R7's careplan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a venous ulcer on his lower right leg.

R7's physician order dated 11/7/19, indicated R7 was to have "Compression devices to bilateral lower extremities" applied daily related to Lymphedema (swelling 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.

R7 was observed on 11/7/19, at 8:07 a.m. sitting in his w/c in his room with his legs unwrapped, waiting for his call light to be answered. R7 stated the nurse had not yet wrapped his legs and stated his legs should be wrapped when he got up, and stated he had to go to the toilet and had been 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 46	F 684		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 47	F 684		

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 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 nurse had told him she was "too busy" to wrap his legs.

R7's care plan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a venous ulcer on his lower right leg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 48 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. Facility policy Accommodation of Needs dated 7/25/16, indicated, facility's staff behaviors should assist resident in maintaining and/or achieving independent functioning, dignity and well-being and accommodate residents' individual needs and preferences. Facility policy Self Determination and Participation dated 7/25/16, indicated each resident should be allowed to choose schedules with times of days for treatments.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 49 Based on observation, interview and document review, the facility failed to ensure ongoing monitoring, comprehensive assessment, and implementation of interventions to promote healing of a facility acquired right and left stump pressure ulcers for 1 of 2 residents (R43) reviewed for pressure ulcers. Finding include: R43's annual Minimum Data Set (MDS) dated 10/3/19, identified R43 had intact cognition and diagnoses included anemia, end stage renal disease, peripheral vascular disease and diabetes mellitus. The annual MDS indicated R43 had one unstageable (not stage able due to coverage of wound bed by slough and/or eschar) pressure ulcer. The MDS identified R43 was at risk of developing pressure ulcers and interventions included nutrition or hydration, pressure ulcer care, applications of ointments/ medications other than to feet. The MDS further indicated R43 required supervision and/or oversight with activities of daily living. R43's Progress Notes (PN) and Weekly Wound Assessment (WWA) were reviewed from 10/16/19, through 11/6/19, and revealed the following: -The WWA dated 10/16/19, indicated R43 had pressure area to the front of right "lower leg" which was noted as a new area, however R43 WWA identify "no" R43's care plan was not reviewed or updated. A subsequent WWA dated 10/16/19, indicated R43 had a pressure area to the front of left "lower leg" wound was previously healed and re-injured related to artificial legs use, however R43 WWA identify "no" R43's care plan was not reviewed or updated. An additional WWA	F 686	1.R43□s wounds have been comprehensively assessed by a registered nurse and care plan updated. Resident has been interviewed and his preferences for the day of the week for assessments and time of day for treatments has been identified in the care plan. Risk and benefits of having wounds comprehensively assessed weekly has been communicated to R43. 2.All residents identified as high risk for pressure development had a new Braden Scale and their care plan was reviewed and updated with interventions as needed. On admission, any resident noted with a pressure wound will be assessed and a wound data collection will be initiated. 3.Education has been provided to registered nurse manager regarding weekly wound assessments, resident preferences and the need to document risk and benefits of non-compliance in these areas. All nursing staff will be educated by 12/29/2019, on expectations of wound care, refusal of care and identification of skin breakdown. The Pressure Ulcer Risk Assessment policy will be reviewed with nursing staff. 4.The director of nursing or designee will be responsible for compliance. Audits will be completed weekly x 4 then monthly x 2, will be done to ensure weekly wound assessments include staging, measurements, treatment plan and care plan updates are done. Communication to physician and resident/family will be audited weekly x 4 then monthly x 2. Results will be reviewed by our Quality committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 686	Continued From page 50	F 686		

dated 10/16/19, indicated R43 had a second pressure area to the front of the left "lower leg" which was noted as a new area, however R43 WWA identify "no" R43's care plan was not reviewed or updated. Additionally, WWA dated 10/16/19, indicated R43 had a pressure area behind of R43 left knee which had noted improvement. Furthermore, WWA dated 10/16/19, indicated R43 had a second pressure area behind of R43 left knee which had noted improvement;
-The PN dated 10/23/19, identified R43 was approached before leaving for dialysis to complete wound assessment of R43's lower stumps and indicated R43 had both of his artificial legs on, and would not take them off for an assessment;
-The PN dated 10/28/19, indicated R43 was getting ready to go to dialysis, floor nurse requested Registered Nurse (RN)-A to "observe" bilateral stumps as R43 did not have his artificial legs on. "Bilateral stumps observed. Pressure area to right lower front leg intact, blanchable redness. Areas behind left knee covered with serous crust, no drainage, erythema or inflammation. Small open area to top of left leg above knee. Skin prep applied, adhesive foam bordered dressing applied to right lower leg and behind left knee." However, the PN lack evidences of measurement and evaluation of current intervention and treatments;
-The PN dated 10/30/19, indicated R43 was seated in the wheelchair with artificial legs on and was approached for wound observation. The PN indicated R43 declined, staff re-approached R43 prior to leaving for dialysis and R43 declined again;
-The PN dated 10/31/19, indicated R43 wound care needed to be done on every Monday and

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F 686	Continued From page 51	F 686		

Thursday, however, the PN indicated R43 "was outside every time staff wanted to do Tx [treatment];"
-The PN dated on 11/6/19, indicated R43 refused observation of both of the stumps, due to R43 had both of his artificial legs on and did not want to take them off. The PN indicated R43 said "they are fine and don't need anything anymore."

R43's medical record was further reviewed and lacked evidence of weekly wound monitoring to include measurements, evaluations of interventions, and consistent treatments to promote healing of the wound. In addition, R43 medical record lack evidence of risk and benefit discussed with R43 regarding refusal of wound treatment and assessment.

R43's care plan date initiated on 9/27/19, indicated R43 was at risk for skin breakdown and 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 treatment was on Wednesday and Sunday: apply skin prep and cover with adhesive foam dressing. However, R43 care plan lack evidences of R43 preference regarding wound assessment and treatment. In addition, R43 care plan lacked direction to staff regarding refusal of wound assessment and treatment.

R43's Pressure Ulcers Care Area Assessment (CAA) dated 10/17/19, identified R43 had an unstageable pressure ulcers and bilateral lower

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F 686	Continued From page 52	F 686		

extremities amputation and was non-compliance with medical recommendations. The CAA directed staff to assist with placement of shrinker socks, insulin management and ambulation with artificial legs.

R43 was interviewed on 11/07/19, at 8:31 a.m. and stated staff usually put the dressing on, however indicated the staff had not observed his wound recently. R43 stated he would not refuse wound care, however preferred wound care was completed prior to putting both artificial legs on for the day.

RN-A was interviewed on 11/07/19, at 8:41 a.m. and stated R43 wound assessment was supposed to be done daily however R43 often refused. RN-A stated R43 was "very resistance and often refused" to take artificial legs off for wound assessment.

RN-A was observed on 11/07/19, at 9:11 a.m. while doing dressing change for R43. RN-A assessed the wound on R43's right stump which measured 0.5 centimeters (cm) by 1.2 cm and described as "superficial, dry." RN-A confirmed that R43 right stump was supposed to have had a dressing on at all times, however, verified R43 wound was not covered prior to the dressing change. RN-A assessed the wound behind R43 left knee which measured 1.5 cm by 1.5 cm and described "no depth, very superficial, resurface very light pink." RN-A confirmed R43 had no additional pressure areas at that time.

R43 and RN-A were interviewed on 11/07/19, at 9:28 a.m. and stated he did not want to take artificial legs on and off for wound assessment on dialysis day and told RN-A he preferred the

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 53 wound assessment to be done before. R43 stated to RN-A "you always" wait until "I" was ready to leave for dialysis with my legs on. RN-A answered, "I know it's my bad." The director of nursing (DON) was interviewed on 11/8/19, at 1:00 p.m. and stated they had a nurse practitioner who was a wound certified nurse and rounded weekly with RN-A to complete weekly wound assessment. DON also stated that she expected a dressing over a pressure ulcer wound and if it wasn't there, it needed to be replaced by staff as soon as possible. DON stated that R43 was always the first one on the list for his weekly wound assessment, however he would often refuse. The facility Pressure Ulcer Risk Assessment policy undated, indicated "Assessment 3 ...Monitoring: a. Staff will perform routine skin inspections (with daily care). b. Nurses are to be notified to inspect the skin if skin changes are identified. c. Nurses will conduct skin assessment at least weekly to identify changes ...Steps in the Procedure 4. Once inspection of skin is completed proceed to the Admission Assessment or Weekly Skin Integrity tool (depending on whether this is a new admission or an existing resident) and complete documentation of findings ... 6. Proceed to care planning and interventions individualized for the resident and their particular risk factors ...Documentation: 9. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risk of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal."	F 686		
F 688	Increase/Prevent Decrease in ROM/Mobility	F 688		12/29/19

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 688 SS=D	Continued From page 54 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion exercises for 1 of 2 residents (R4) reviewed for limited range of motion. Findings include: R4 was observed on 11/4/19, at 6:29 p.m. sitting in her Broda chair in her room with her left hand fingers curled in. R4's Quarterly MDS dated 10/23/19, indicated R4's cognition was impaired, was totally dependent on staff assistance for dressing and personal hygiene and did not reject cares. R4's Quarterly MDS indicated R4 had functional limitation in ROM with both upper and lower	F 688	1.R4 will have a comprehensive review of all extremities to identify any areas with limits in movement. The nursing staff has been working with hospice agency to establish a range of motion program and to obtain some type of splint and or palm protector for R4□s left hand. 2.Residents with Functional Maintenance Plans in place will be reviewed to ensure interventions are in place and the care plan is up to date. This has the potential to affect all facility residents. 3.All licensed staff will be in-serviced by December 29, 2019 on range of motion, identification of change in range of motion and on the facility policy Rehabilitative Nursing Care.	

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F 688	Continued From page 55 extremities. Finger contractures were not identified on the quarterly assessment. R4's Care Area Assessment (CAA) dated 1/11/19, indicated R4 had limited ROM, bilateral shoulder arthritis and contracture. R4's CAA did not indicate location of the contracture and did not indicate ROM exercises were to be performed. R4's Significant Change Minimum Data Set (MDS) dated 7/26/19, indicated R4's cognition was impaired and R4 had diagnoses of Arthritis, 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.	F 688	4.The director of nursing or designee will be responsible for compliance. Audits will be completed on residents with Functional Maintenance Plans to prevent reoccurrence of deficient practice daily x 4 weeks, weekly x 1 month and then monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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

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F 688	Continued From page 56	F 688		

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 could not straighten our her fingers and was concerned about it. R4 stated she did not want the left fingers to get any worse. R4 tried to open up her left hand, but could not stretch out her fingers all the way open.

Licensed practical nurse (LPN)-D stated on 11/7/19, at 1:40 p.m. she had not assessed R4's left fingers for contractures.

Nursing assistant (NA)-J stated on 11/7/19, at 1:40 p.m. NAs did not perform ROM or exercises for R4's left hand. NA-J pulled out her NA care sheet and confirmed ROM/exercises was not identified on the care sheet for R4.

Registered nurse (RN)-A, who was also nurse manager, stated on 11/7/19, at 1:42 p.m. R4 had a history of stroke and frozen left shoulder and guarded her left arm because of pain and did not use her left hand. RN-A stated R4 did not receive restorative therapy. RN-A stated ROM could be done with R4 for comfort but was presently not being done by staff. RN-A called on the telephone and put therapy director (TD) on speaker and

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F 688	Continued From page 57	F 688		

asked if R4 had been seen by therapy. TD stated therapy had worked with R4 in the spring for passive ROM for the upper part of body for pain management. TD stated therapy had not identified hand/finger contractures for R4 and R4 was able to open both hands. TD stated therapy could evaluate and provide three visits she though. RN-A stated she would e-mail hospice for R4 to be evaluated by therapy for ROM for her left fingers contractures.

R4 was observed on 11/8/19, at 9:52 a.m. sitting in her Broda chair in her room. R4 stated a couple of staff had come and talked to her about her left hand fingers. R4 stated she did not know what had been decided yet but wanted ROM to help with the fingers not getting worse. R4 stated she was not interested in having a hand splint only wanted ROM exercises.

Nursing assistant (NA)-J stated on 11/12/19, at 9:43 a.m. that R4 lets her wash her hands. NA-J stated R4 could open up some of her fingers on the left hand, but not all the way open.

Hospice nurse (HN) stated on 11/8/19, at 11:32 a.m. she was here to see R4. HN stated R4 kept her fingers on her left hand curled and stated R4 could open up her fingers with some pain. HN stated she had not noticed R4 could not open her fingers up all the way and would assess and evaluate for contractures and ROM.

HN stated on 11/12/19, at 9:31 a.m. she had now identified contractures for R4's left fingers. HN stated R4 could only partially open up her left fingers and was going to have therapy evaluate and implement ROM and splint with some wear time.

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F 688	Continued From page 58 R4's progress note dated 11/8/19, indicated HN had discussed with RN-A about ordering an Occupational Therapy evaluation for R4's left hand contractures to see what could be done to increase ROM and stiffness and order was written. Director of nursing (DON) stated on 11/8/19, at 1:50 p.m. she was not aware of R4's left fingers contractures. DON stated on 11/12/19, at 11:48 a.m. R4 should have been assessed for contractures before survey process. Facility policy Rehabilitative Nursing Care undated, indicated each resident admitted would receive Rehabilitative nursing care and would be developed and coordinated through the resident's care plan. The policy indicated residents would be assisted with exercises between visits of the therapists and would be assisted with their routine range of motion exercises.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	Base Board Heaters	12/29/19

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 689	Continued From page 59 review, the facility failed to ensure heat registers were monitored for safe temperatures in resident rooms for 1 of 33 residents (R29) with baseboard heaters. In addition, the facility failed to comprehensively assess causative factors of falls and develop and implement appropriate interventions for 1 of 3 residents (R7) reviewed for falls and failed to identify and comprehensively reassess continued use of a mechanical lift following a change in mobility and develop interventions for 1 of 1 resident (R30) reviewed accidents. Additionally, the facility failed to provide supervision to reduce resident to resident altercations for 5 of 5 residents (R15, R33, R55, R56, R57) in the memory unit. Furthermore, the facility failed to assess, develop and/or implement interventions to promote safe smoking and storage practices for 2 of 2 residents (R43, R25) reviewed for smoking hazards. Findings include: R29's Significant Change Minimum Data Set (MDS) assessment dated 9/9/19, identified severe cognitive impairment and hallucinations. R29's Significant Change MDS indicated R29 required extensive assistance of two staff for bed mobility, transfers, and toileting. In addition, R29's diagnoses were identified to include dementia, type 2 diabetes, depression and anxiety. R29's 11/6/19, care plan identified he had a self-care deficit related to aggressive behavior, cognitive loss associated with dementia, weakness, and incontinence. R29 required extensive assistance of up to two staff to turn and reposition in bed, extensive assistance of 1 staff to transfer with a sit to stand lift. R29 had weakness and limited physical mobility, and	F 689	R29□s bed was moved away from base board heater immediately on 11/01/2019. Room audits were done on all rooms on the same day to ensure beds were not next to the base board heater. Temperatures of base board heaters were checked by the director of maintenance as well. This incident was reported on the Nursing Home Incident Reporting site on 11/01/2019. This has the potential to affect all facility residents. Nursing, housekeeping and maintenance staff were educated to not to place bed and/or personal items next to heaters in resident rooms. Resident room temperatures will be checked monthly or when resident or family has concerns about room temperature. The maintenance director or designee audits on room placement and temperature of the baseboard heaters monthly x 3. The nursing staff has and will continue to complete weekly checks x 2 weeks then monthly x 1 to ensure safety. Results will be reviewed by our Quality committee for further recommendation. Falls/INJURY R7 was evaluated by occupational therapy (OT) for wheelchair positioning on 9/09/2019 for fine motor coordination, heel strike during wheelchair mobility with the goal to maintain upright positioning when in wheelchair. R7 continues to work with OT and physical therapy (PT). In addition, a new fall and pain assessment should be completed after every fall, they will be done by 12/17/2019. IDT will meet and review R7□s care plan	

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

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F 689	Continued From page 60 required extensive assist of one staff to move in his wheelchair. R29 had impaired communication related to cognitive loss associated with dementia. An incident report dated 11/1/19, at 4:30 p.m, indicated R29 had sustained a burn to his left leg. The incident report indicated R29's bed was in the lowest position next to the wall and was in contact with the electric baseboard heater when the resident sustained the burn. According to the incident report, the maintenance director (M) had determined the heater had an intermittent heating cycle. Further the maintenance director had reported at the time of his inspection, the heater was cool to the touch. R29's progress note dated 11/1/19, at 6:36 p.m., indicated R29 was discovered by staff with his left leg against the heat register in his room. The progress note indicated R29's leg had an 8 centimeters (cm) by 2.5 cm pink, area on the outer aspect of the left lower leg and indicated staff had applied a cold compress to the area. In addition, R29 was noted by staff to have been alert with no signs of pain. R29's physician was subsequently contacted and staff received an order for Silvadine (burn cream). R29's bed was immediately moved away from the wall with the heater. The Administrator, the director of nursing (DON) and M had determined the heater had been on long enough to expose R29's skin at the heating cycle. Following the incident, all rooms were checked to ensure beds were not placed directly against wall heaters, and staff education was provided to keep R29 away from the heater. In addition, the maintenance director was responsible to oversee periodic temperature monitoring of the wall heaters for the next 24	F 689	and update as needed by 12/19/2019. All residents in the facility will be reviewed by the IDT by 12/29/2019 to identify any positioning and transferring concerns. If there are any concerns an OT evaluation will be done. Any adjustments will be noted in the residents EMR and their care plan updated as needed. The therapy department (PT), OT and speech therapy (ST) screen all residents prior to their routine IDT reviewal that is done quarterly. Future residents will be assessed by OT upon admission for proper wheelchair and positioning Audits will be done weekly x 4 weeks then monthly x 2 to ensure compliance. Audits on all falls to ensure fall and pain assessment will begin immediately. R30 is transferred with a full body lift sling. The sling is based on body weight and to accommodate bilateral lower extremity amputations. Existing residents requiring full body lift for transfers will be assessed for barriers to safe transfers by 12/16/2019. For all, the care plan and care sheets will be updated. This has the potential to affect all facility residents. Nursing staff will be in-serviced on proper full body lift sling sizing and barriers to safe transfers when a mechanical lift is used by 12/29/2019. Audits for full body lift appropriateness will begin 12/17/2019 weekly x 4 weeks then monthly x 2 to ensure compliance. Failed to provide supervision to reduce resident to resident altercations for 5 of 5	

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

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F 689	Continued From page 61 hours. R29's physician progress note dated 11/4/19, identified R29 sustained a 2nd degree burn to the left lower leg. Staff were to continue Silvadine cream twice daily and to keep the wound clean and covered. Observation on 11/5/19, at 1:34 p.m. identified R29's electric heater was located under an exterior window along the floor baseboard. During observation and interview on 11/5/19, at 2:29 p.m. with M-A, R29's heater was observed to be an electric baseboard heater with a metal outer surface. At that time, the surfaces and and internal temperature of R29's heater were measured by M-A with an infrared thermometer to be 105 degrees Fahrenheit (F) on the outer metal cover. The top of the heater measured 119 degrees F, and the internal heating element was 123 degrees F. M-A agreed residents with fragile skin could be at risk for accidental burns when in close contact with the heater. M-A stated they had determined R29's burn was caused by irradiation from the heated air inside the heater, exiting the vent. M-A said following R29's incident, he had checked all rooms on the 100 and 200 wings to ensure no other beds were in direct contact with those types of heaters. M-A stated he thought in order to cause a burn, the heater surface had to reach between 133 and 135 degrees F, and skin needed to be in contact with the heater for an extended period of time. M-A was unaware of the direction in the regulatory guidance that indicated burns could be sustained after exposure to temperatures over 120 degrees F in excess of 5 minutes. M-A was unable to find a manufacturer or serial number for	F 689	residents (R15, R33, R55, R56, R57) R57 and R56 have discharged from the facility. R55 is deceased. R33 was assessed and no longer resides on the secured memory care unit. R15 was admitted to a geriatric psych unit this week and will and will be reassessed for the secured unit after in-patient stay is complete. The staffing ratio has been re-evaluated by the director of nursing and staffing has been adjusted to accommodate the existing residents on this unit. Staffing patterns will continue to be adjusted for any future resident admissions. Existing residents with behavior concerns will have their care plan reviewed and target behavior identified and appropriate interventions added. Future residents being considered for admission to the secured unit will be screened by the IDT team prior to admission to identify target behaviors and interventions. Mandatory staff education on dementia was held on 12/4 and 12/5, 2019. This training focused on Connection, leadership and the providing the next level of care. Understanding how people with dementia experience their new and ever-changing world. Understanding the world in which we support helps us to provide quality care that allows people to shine. Progress notes, risk management reports will be reviewed every weekday for behavior concerns beginning12/17/2019 x 4 weeks, weekly x 1 month and then monthly x 1.	

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	245304	A. BUILDING _____ B. WING _____	C 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

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F 689	Continued From page 62 any of the heaters to determine manufacturer's recommendations for safe heater use, and stated the heaters had been in use for at least 30 to 40 years. M-A further acknowledged the heaters were not checked for safety prior to the initial use in the fall of the year. In addition M-A verified staff had not been reminded to move any beds or items off, or away from, heaters. M-A stated he had monitored the temperatures of the room following the burn, but had not monitored heater surface temperatures. During interview on 11/5/19, at 2:32 p.m. nursing assistant (NA)-B stated he had reported a concern related to hot heaters to the nurse manager, registered nurse (RN)-A, and DON a week before R29 was burned. NA-B stated R29's bed was too low and close to the heater. NA-B said he had raised the bed up a couple inches higher than the floor because the heater was hot, but stated he had not moved the bed away from the heater on the wall. NA-B said RN-A had advised him to place R29's bed in the lowest position, which unbeknownst to staff, put R29 in contact with the heater. NA-B stated he measured the temperature of all the room heaters after the incident and found 4 or 5 of room heaters above 120 degrees but was unable to remember which rooms. During observation and interview on 11/7/19, at 10:13 a.m. licensed practical nurse (LPN)-E stated R29's bed was in the low position next to the heater at the time of the burn. LPN-E stated the burn was initially a large dark red area with no blister however, R29 developed a blister as a result of the burn. During observation at the time of the interview, the burn on R29's left lower leg appeared as an irregular 5 cm by 3 cm wound	F 689	Failed to assess/develop and/or implement interventions to promote safe smoking/storage practices for smoking R43 and R25 R43 and R25 will have smoking assessment, care plan review and be re-educated on the facility smoking policy completed by 12/29/2019. Current smokers will receive re-education on the facility smoking policy 11/11/2019. Future residents who smoke will continue with smoking evaluation upon admission and will have the facility smoking policy reviewed. This has the potential to affect all residents that are current smokers. Facility staff will receive education on the facility smoking policy along with smoking material storage and will be completed by 12/29/2019. Audits for storage of resident smoking materials and resident smoking interventions will be completed daily x 4 weeks, weekly x 1 month then monthly x 1 to ensure compliance. Results will be reviewed by our Quality committee for further recommendation. The director of nursing and/or designee will be responsible for compliance	

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F 689	Continued From page 63	F 689		

with bright red margins, with the inner wound bed 90 percent (%) covered with greenish/yellow tissue, and the outer 10 % of the wound bed was beefy red.

During interview with R29 on 11/7/19, at 10:15 a.m.he said he had no pain in his lower left leg. R29 was unable to recall the events surrounding his burn, was aware of person only, and was not able to be interviewed further.

During interview on 11/8/19, at 2:10 p.m. DON denied being aware staff were concerned about the heater temperatures. DON stated there was no documentation of heater surfaces being too hot. DON confirmed the heater temperatures had been monitored initially after the burn. DON stated she expected all rooms to be monitored and stated staff were educated not to put beds next to the heater after R29's burn. However, DON stated she was unable to verify which staff had received education, and verified the revised policy was not reviewed after R29's incident.

Review of a 11/2/19, staff Meeting Sign In Sheet identified staff on duty had received education to keep beds away from the heaters however, there was no evidence to determine whether staff who were not on duty at the time of the incident had been educated on heater safety.

During interview on 11/8/19, at 10:23 a.m. the medical director (MD) stated he was aware a resident had received a burn, but was not aware of the circumstances. MD stated the building was old, but replacing the heaters was likely not an option. However, confirmed preventative measures and policies should be in place to prevent burns from heaters. He expected the

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

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F 689	Continued From page 64	F 689		

facility to develop a policy to establish a safe-zone around heaters to keep all beds, sheets, chairs out of the established safety zone to prevent burns and expected the management team to provide training to all staff about heater safety.

Review of the facility's 12/1/17, Room Temperature Policy identified resident beds and items were to be kept a safe distance from the baseboard heaters to prevent hazards. The policy did not identify what a safe distance or safe temperature was, but indicated all concerns were to be brought to management.

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

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

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F 689	Continued From page 65	F 689		

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 previous fracture" R30 indicated on 3/5/19, that "his leg was hit on the lift" and nursing assistants (NA) reminded to handle R30's left leg to ensure support during transfers. The file identified NA-K was one of the NA who had worked with R30 during that time.

R30's incident report dated 3/2/19, indicated R30 reported "the staff was transferring him in the hoyer one staff was in the back helping resident sit up straight the other staff guiding resident's leg, resident stated that the nursing assistant guiding his legs dropped his leg, causing pain."

R30's Emergency Medicine Provider Note dated 3/2/19, indicated R30 was seen for complaints of left leg pain and was diagnosed with a fractured tibia closed with noted surrounding sclerosis as well.

R30's annual MDS dated 9/16/19, identified R30 had intact cognition and diagnoses which included quadriplegia and anemia. The annual MDS indicated R30 required total dependence for his transfers.

R30's care plan revised 9/17/19, identified R10 was totally dependent on staff for all cares and directed staff to provide assist of two staff with full mechanical lift for transfers.

R30's Diagnosis report dated 11/8/19, indicated R30 had diagnoses which included squamous cell carcinoma of skin of left lower limb, right and left leg above the knee amputation.

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

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F 689	Continued From page 66	F 689		

R30's medical record lacked evidence of reassessment of transfers with the mechanical lift following his left lower extremity fracture on 2/15/19.

DON was interviewed on 11/8/19, at 1:20 p.m. and stated it was her expectation for staff to communicate when a resident transfers were difficult and the resident would be reassessed for proper equipment and lift use.

NA-K was interviewed via telephone on 11/12/19, at 4:17 p.m. and stated he had assisted with another NA transfer R30 with the mechanical lift. NA-K recalled he was controlling the lift while another NA was holding R30's leg due to R30 had his leg in a large brace. NA-K remembered the transfer having been difficult due to R30's leg brace and the support needed for R30's leg. NA-K stated during the transfer R30 "accidentally" hit his leg on the lift as R30 was unable to keep his leg positioned comfortably with the leg brace on when up in the lift. NA-K remembered R30 indicating his leg hurt from hitting his knee of the lift. NA-K was unable to recall if the nurse was notified regarding R30's leg hitting the lift and/or regarding R30's difficult transfers with the lift.

The facility Safe Lifting and Movement of Residents Policy undated, indicated resident safety, dignity, comfort and medical condition would be incorporated into goals and decisions regarding the safe lifting and moving of residents. The policy indicated assessments of individual resident needs for transfer assistance was completed on an ongoing bases and staff would document resident transferring and lifting needs in the care plan. The policy indicated the

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

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F 689	Continued From page 67	F 689		

assessment would include resident preference for assistance, resident degree of dependency, resident size, weight bearing ability, cognitive status, if the resident was cooperative with staff and resident goals. Furthermore, safe lifting and movement of residents was part of an overall safety program which involved employees in identifying problem areas.

R7's Fall Risk Assessment dated 10/27/19, indicated R7 was a High fall risk.

R7's Quarterly MDS dated 10/28/19, indicated R7's cognition was intact and had fallen more than two times since the last assessment completed on 8/1/19. R7's Quarterly MDS indicated R7 had diagnoses which included generalized muscle weakness and anxiety. R7's MDS indicated R7 needed extensive staff assistance with transfers and all activities of daily living and did not reject cares.

R7 was observed on 11/4/19, at 6:55 p.m. sitting in his wheelchair (w/c) near the front desk, sitting upright in his w/c.

R7 was observed on 11/7/19, at 8:07 a.m. sitting in w/c in his room with his call light on and stated he had to go to the bathroom. Couple minutes later Registered nurse (RN)-A entered R7's room with an EZ stand (mechanical lift) to transfer R7.

R7 was observed on 11/7/19, at 1:33 p.m. sitting in w/c in his room leaning back in his chair, not sitting upright. R7 stated, "I fell to my knees last night, no hurt, it just happens." R7 explained he thought he was reaching for something but was unsure.

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

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F 689	Continued From page 68	F 689		

NA-J stated on 11/12/19, at 9:42 a.m. R7 was a fall risk and had fallen recently. NA-J stated she thought R7 slides out of his chair and explained R7 always sits like he is sliding down and stated R7 sleeps in his w/c. NA-J verified R7's reacher was hanging up on the backside of R7's door out of reach in a plastic sleeve. NA-J stated she had never seen R7 use the reacher.

R7 was observed on 11/12/19, at 1:33 p.m. sitting in his w/c in his room not sitting upright, leaning back. R7 stated he reaches for things and slides out of the w/c onto his knees on the floor and stated he had not gotten hurt from it. R7 stated he just forgets to use the reacher. R7 stated he thought he was sleeping in his w/c the last time he fell and he had seen the remote near his hand. R7 stated he thought his w/c was wide enough, but stated the seat of the w/c could be longer and the back up his w/c up further and then the w/c would be more comfortable. R7 stated maybe he needed a larger w/c and explained he had just fell forward.

Review of R7's fall incident reports revealed:
-R7 was found on the floor in his room on 6/11/19, at 11:49 p.m. Incident Report indicated R7 stated he was reaching when he slipped off his w/c to his knees. No intervention for root cause was indicated on the fall report.
-R7 was found on the floor in his room on 6/18/19, at 9:45 a.m. on his knees. Incident Report indicated R7 stated he was reaching for something and slid out of his chair. The report indicated R7 was a big man who had difficulty sitting up straight. No intervention for root cause was indicated on the report.
-R7 was transferred and right leg gave out and lowered to the floor to his knees on 6/27/19, per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 69	F 689		

progress note. No Fall Incident Report received.
-R7 was found on the floor in his room on 7/1/19, at 9:48 a.m. Incident Report indicated R7 stated he was reaching when he slipped out of his w/c. No intervention for root cause was indicated on the report.
-R7 was found on the floor in his room on 9/2/19, at 6:30 p.m. Incident Report indicated R7 stated he had leaned too far forward and slipped out of 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

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

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F 689	Continued From page 70	F 689		

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 R7 should use a reacher but stated she did not think there was a reacher in R7's room. DON stated she thought R7 falls were actually from him falling asleep in his w/c and not from him reaching, and explained R7 was always "sleepy". DON stated R7 had seen a neurologist for right side upper and lower symptoms of numbness and was going to be scheduled for additional testing.

RN-A, nurse manager stated on 11/8/19, at 1:00 p.m. she was unavailable to go over R7's fall reports and to talk with DON about R7's falls.

DON stated on 11/8/19, at 1:02 p.m. the IDT met daily Monday through Friday and discussed residents' falls. DON stated R7 had just fallen yesterday and IDT was trying to come up with an appropriate intervention for his falling for reaching. DON stated she was not aware if therapy had evaluated R7 for fitting of his w/c. DON stated the nurse managers were responsible for care planning and implementing the fall interventions. DON stated staff should follow residents' care plans.

Facility policy Falls -- Clinical Protocol undated, indicated staff would evaluate resident fall and attempt to define possible cause within 24 hours of the fall and identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The fall policy indicated if underlying causes cannot be readily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 71	F 689		

identified or corrected, staff were to try various relevant interventions, based on assessment of the nature of the the fall until falling reduces or stops or until a reason is identified for its continuation.

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.

R15's Care Area Assessment dated 12/7/18, indicated R15 required a secured unit due to her wanting to leave the facility and her memory loss. R15 had severe cognitive impairment and was unable to focus on what others were saying and recall what was said.

R15's care plan printed on 11/6/19, indicated R15 had the potential to be physically aggressive related to dementia, and poor impulse control. R15 was bothered by loud noises. R15 was independent with ambulation and transfers. Interventions included: When R15 became agitated to intervene before agitation escalates, and guide away from source; Monitor and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 72	F 689		

document any signs of R15 posing danger to self or others; Staff to be aware of R15 activity on the unit and keep R15 from residents that tend to invade her personal space; Cue and supervise as needed; Redirect when R15 seems confused or at risk for doing something that might cause distress; Monitor pacing, wandering or crying occurrences.

Review of Daily Staffing Sheets since July of 2019, revealed that the 300 memory unit was staffed during day and evening shift with two staff and the night shift one staff.

Review of R15 resident to resident altercations Vulnerable Adult (VA) - Incident reports revealed that R15 had four altercations since July 2019, with physical aggression with other residents.
-On 7/27/19, R15 was able to place her hands around R57's neck, and then reach out to hit R56 in the arm before staff could intervene. Report indicated that constant awareness of other residents and their behaviors was key to keeping everyone safe and secure.
-On 9/19/19, R15 and R55 were identified as unsupervised when licensed practical nurse (LPN) heard screaming and swearing. When LPN got within eye sight she found R15 and R55 punching each other in the face. The report also indicated that the second staff was off the unit at the time of the altercation.
-On 10/11/19, R55 was sitting in his wheelchair near the exit door when R15 was observed to walk up behind R55 and rub his head. R55 was seen to get up from his wheelchair and starting pushing R15 before staff could intervene.
-On 10/22/19, R55 was sitting in his wheelchair and R15 walked up and leaned in and said something to R55 then slapped him in the face

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 73	F 689		

with her open hand before staff could intervene.

On 11/4/19, at 1:17 p.m. R15 was observed sitting at the table in common area with no staff present. At 1:20 p.m. licensed practical nurse (LPN)-F entered the common area just as R15 got up and walked down the hall to go enter a room. The common area was unsupervised for three minutes where R15 was sitting.

On 11/4/19, at 5:21 p.m. R33 was observed sitting at a table yelling and R15 got up from her table walked over to R33 and stated something to her about a fist in your nose (unable to identify exactly what she said) then returned to her table. There were no staff present in the common area where these two residents were. At 5:25 p.m. kitchen staff entered the common area followed by a direct care staff. The common area was unsupervised for four minutes.

On 11/4/19, at 5:31 p.m. R15 was observed up walking around and stopped to play with a resident's hair who was sitting at the table. There was no staff present in the common area. There was an activity staff in the next room visiting with another resident but unable to visually see R15. At 5:39 p.m., the activity staff entered the common area where R15 was located. The common area was unsupervised for six minutes.

On 11/5/19, at 8:08 a.m. trained medication assistant (TMA)-A stepped out of a resident room and asked LPN-A for assistance. LPN-A left the common area where R15 was sitting and assisted the other staff. At 8:16 a.m., LPN-A returned to common area. The common area with residents sitting at tables and wheeling around were unsupervised for eight minutes. At 8:22 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 74	F 689		

LPN-A left the common area where there were residents including R15. At 8:30 a.m., kitchen staff arrived to common area. The common area was unsupervised for eight minutes.

On 11/6/19, at 11:13 a.m. R15 was observed walking down the hallway and both staff were in another resident room. There was an activity staff in the common area but this staff was unable to visually see R15 and her whereabouts.

On 11/7/19, at 7:51 a.m. LPN-K left common area with residents (including R15) present to assist the other staff in a room. At 7:56 a.m, LPN-K returned to the common area having left the area unsupervised for five 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.

During interview on 11/4/19, at 5:25 p.m. NA-D stated that R15 always had aggressive behaviors and someone needed to watch her. NA-D stated that the nurse had medications to give on the memory unit and the 200 wing so that left NA-D alone at times and it was very hard to monitor everyone. NA-D stated that when she needs assistance with a resident the nurse was the one who helped and verifies that the residents were left unsupervised during those times.

During interview on 11/5/19, at 8:53 a.m. TMA-A indicated monitoring R15 included watching her as R15 was very keen on another male resident. TMA-A stated "we cannot monitor all the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 75	F 689		

residents when we are in getting residents up" and that was a safety concern.

The activity director (AD) was interviewed on 11/6/19, at 10:20 a.m. and stated that the activity department did not have set hours on the memory unit. AD stated the activity staff were not called to assist with monitoring residents on the memory unit while staff were completing cares as it was not part of the activities daily duties.

The assistant director of nursing (ADON) was interviewed on 11/6/19, at 10:45 a.m. and indicates that R15 had quite a few incidents when she lashed out unprovoked. ADON stated staff kept an eye on R15, and R15 was supposed to be always in eye sight of staff. ADON stated if staff need to be in a room and could not monitor the common area they needed to radio for someone to come, as there needed to be someone monitoring at all times as there were other residents with behaviors. ADON agreed that R15 continued to have resident to resident altercations with no resolution. ADON stated she was unsure if anyone had looked at the times the altercation happened to see if there was a pattern.

During interview on 11/6/19, at 11:12 a.m. DON indicated R15 was to be monitored but was not on one to one supervision as the facility did not have those resources. DON stated there were residents on that unit that required two staff assistance and during those times staff had to radio call for assistance to monitor residents in the common area. DON stated it was her expectation that residents were not left alone in the common area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 76	F 689		

On 11/6/19, at 2:09 p.m. RN-A indicated there should have always been one staff within eyes view of the hall and common area ideally. RN-A stated there were times that did not happen as the nurse went to give pills but that was why staff carried radios so they can ask for help.

On 11/7/19, at 8:45 a.m. licensed social worker stated staff were expected to be with R15 when she was in the common area.

On 11/7/19, at 3:13 p.m. NA-I stated someone had to watch the residents when they were in the common area at all times because "you never know what they will do."

Review of undated, Resident to Resident Altercation policy identified staff were to monitor residents for aggressive or inappropriate behaviors towards others.

Review of the 9/27/19, Abuse Policy and Procedure indicated staff were to institute measures to address the needs of residents to minimize the possibility of abuse. The Abuse Prevention Program section indicated staff were committed to protect residents from abuse. The policy also indicated staff will identify occurrences and patterns of potential abuse and implement changes to prevent future occurrences.

R43's annual MDS dated 10/3/19, identified R43 was current tobacco user and had intact cognition. R43's annual MDS indicated R43 diagnoses included anemia, end stage renal disease, peripheral vascular disease and diabetes mellitus. Furthermore, R43's MDS indicated R43 required supervision and/or oversight with activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 77	F 689		

R43's Smoking Review dated 10/15/19, identified R43 did not currently smoke, however intended to smoke. The review indicated R43 had a history of smoking related incidents which included burning self, burning clothing, burning furniture, dropping ashes on self" and indicated R43 "must wear smoking apron" and utilize cigarette holder when smoking. The review indicated staff reviewed the policy related to smoking times and storage of smoking materials with R43, however lacked evidence regarding safe storage of smoking materials.

R43's Care Plan revised on 10/23/19, indicated R43 was currently a smoker and directed staff to assist R43 in wearing smoking apron every time he went to smoke, instruct about smoking risks and hazards, smoking cessation aids, instruct facility policy on smoking: locations, times, safety concerns, notified charge nurse immediately if it was suspected R43 had violated facility smoking policy, observed clothing and skin for signs of cigarette burns, R43 could smoke unsupervised, using a cigarette holder and smoking apron on his lap. R43 was able to light his own cigarette, keep lighter, smoking supplies and roller at bedside.

R43 Progress Note (PN) were reviewed from 8/30/19, through 10/29/19, and revealed the following:
-On 8/30/19, the PN indicated the Director of Nursing (DON) observed two open areas on R43's inner index finger and middle finger. R43 was identified as a smoker and used "index and middle finger to hold cigarette." A subsequent PN dated 8/30/19, indicated R43 was noted with burn mark on his hand that was related to smoking,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 78	F 689		

R43 was deemed unsafe to smoke without supervision on the property. The PN indicated R43 did not wish to stop smoking and agreed to smoke off of the property;
-On 9/10/19, the PN indicated Social Worker (SW) talked with R43 about not being safe to smoke and offered a holder to protect R43's fingers and wearing an apron to protect R43 from burning clothing;
-On 9/11/19, the PN indicated R43 was assessed to have been safe to smoke with the following protective devices cigarette holder and smoking apron, R43 had agreed to use both of the devices;
-On 9/19/19, the PN indicated R43 was observed to have been outside smoking "with out his special gloves or smoking apron per facility agreement" R43 stated "I just got back". R43 was educated to wear the smoking gloves and apron for safety reasons;
-On 9/20/19, the PN indicated R43 lost his smoking privileges due to not wearing his safety devices for smoking;
-On 10/29/19, the PN indicated R43 was given a smoking ring for safety and agreed to use it when smoking.

R43 was observed on 11/6/19, at 8:27 a.m.. in the designated smoking area outside of the building, R43 removed his cigarette and lighter from his jacket and lit his cigarette. R43 was observe without a smoking apron and/ or cigarette holder or ring. R43 was seated in his wheelchair while smoking and was observed to ash on the ground between his legs. While R43 was ashing his cigarette R43 was observed to drop white ashes on to his pants. R43 did not have cigarette burns on his clothes, hand and/ or wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 79	F 689		

R43 was interviewed on 11/6/19, at 8:50 a.m. and stated that "the staff does not tell me or give me any instruction about going out to smoke." R43 stated he did not have cigarette ring or holder and unable to locate his smoking apron. R43 indicated it was ok for him to leave his cigarette and lighter unlock on his bedside table. At the time of the interview R43 was observed to have had his cigarette, tobacco and lighter unlocked on top of his bedside table.

NA-C was interviewed on 11/6/19, at 8:41 a.m. and stated R43 smoked independently and NA-C was unaware of any supplies R43 needs to smoke.

LPN-D was interviewed on 11/6/19, at 11:08 a.m. and stated R43 never notified anyone when he went to smoke. LPN-D indicated R43 was supposed to go out with a smoking apron and cigarette holder. LPN-D stated when she would see R43 without a smoking apron, she would remind him he needed one.

DON was interviewed on 11/08/19, at 1:14 p.m. and stated that it was her expectation for staff and residents to follow the care plan. DON explained R43's smoking ring was on order due to his cigarette was difficult to find a right ring that fit. DON confirmed R43 should have had a cigarette holder in his room available for use. DON stated R43 had been non-complaint regarding use of his smoking apron and cigarette holder and indicated staff would spot check to make sure R43 smoked safely.

The facility Smoking Policy-Residents revised 11/8/19, indicated any residents or visitor who did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 80	F 689		

not comply with rules regarding smoking would be asked to restrict and/ or forfeit their smoking privileges. Policy indicated smoking assessment would be completed before resident could smoke and " Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring fire retardant smoking aprons) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues ...Lighters MUST be returned to nurse's station when coming in from smoking."

R25's MDS dated 9/11/19, identified diagnoses that included depression and end stage liver disease. R25's MDS indicated R25 was cognitively intact.

R25 was interviewed on 11/6/19, at 11:49 a.m. and stated he smoked a half pack of cigarettes per day. R25 indicated the rules were smokers had to stay in a specific area outside which was away from the entrance. R25 stated he had his cigarettes and lighter in a shelf in his room.

R25 was interviewed again on 11/7/19, at 11:29 a.m. and stated he rolled his own cigarettes with supplies kept in his room. R25 indicated that he also kept his lighter in his room. The supplies and lighter were visible on a shelf under a refrigerator. The lighter was noted to be a refillable type. R25 brought out lighter fluid kept in an unlocked drawer of a bedside table. R25 stated he had not been told he could only use disposable lighters.

LPN-E was interviewed on 11/7/19, at 11:29 a.m. and verified that residents were allowed to keep cigarettes and lighters in their rooms and did not need to keep the supplies locked up. LPN-E stated the policy was changed from requiring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 81	F 689		

cigarette supplies from being locked at the nursing station to allowing residents to keep in their rooms because there was a complaint made to the ombudsman who indicated the materials were property of the residents.

R25's care plan dated 10/14/19, indicated R25 was a smoker and outlined the following: The resident will not suffer injury from unsafe smoking practices through the review date; Instruct resident about smoking risks and hazards and about smoking cessation aids that are available; Instruct resident about the facility policy on smoking: locations, times, safety concerns; Monitor oral hygiene; Notify charge nurse immediately if it is suspected resident has violated facility smoking policy; Observe clothing and skin for signs of cigarette burns; The resident can smoke unsupervised; The resident is able to: (light own cigarette, keep lighter at bedside....).

R25 signed a smoking policy on 9/20/19. The policy dated 9/20/19, indicated that lighters must be in a locked box at the nurses' station, that all smoking products will be stored in the locked box and the residents were not permitted to keep cigarettes or supplies in their possession.

Social Worker (LSW)-A was interviewed on 11/8/19, at 8:42 a.m. and confirmed that the current smoking policy could not be enforced because cigarettes and supplies were considered personal property of the residents per the ombudsman. LSW-A also stated if the resident had holes in their clothes, they could not be forced to wear an apron. Residents were required to have a smoking assessment and if deemed to be unsafe, the privilege was taken away. The residents could not have a cigarette until they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 82 were determined to be safe. LSW-A was not aware that R25 kept lighter fluid in his room. LSW-A stated she did not do room searches, but indicated the lighter fluid would be taken away.	F 689		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staff	F 725	1.It is the facility policy to ensure we have sufficient staffing to meet the needs of all	12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 83 were available to meet resident needs for 4 of 5 residents (R44, R43, R46, R7) dependent on staff for activities of daily (ADLs) and for 5 of 9 residents (R24, R12, R18, R37, R51) whom expressed concerns during resident council meeting. In addition, the facility failed to provide supervision to reduce resident to resident altercations for 5 of 5 residents (R15, R33, R55, R56, R57) in the memory unit. The lack of sufficient nursing staffing had the potential to affect all 51 residents in the facility. Findings include: R44 was observed on 11/8/19, at 7:40 a.m. with his call light on. At 7:59 a.m. R44 indicated he had been on the bed pan waiting for "30 to 45 minutes" and needed assistance to get off of the bed pan as he had "been done for a long time." At 8:05 a.m. nursing assistant (NA)-A was observed to answer R44's call light when entering R44's room R44 stated to NA-A he had been "waiting more than I should." R44 was observed to have had a bowel movement NA-A provided pericares and assisted R44 off of the bed pan. R44 stated to NA-A he had been waiting "45 minutes" and NA-A replied "we are working as fast as the two of us can." R44's quarterly Minimum Data Set (MDS) dated 10/7/19, identified R44 had intact cognition and diagnoses which included dementia and manic depression. The MDS indicated R44 required extensive assist with toileting and was frequent incontinent of bowel without a toileting program. R44 was interviewed on 11/8/19, at 8:15 a.m. and stated staff when staff would call in he would wait a long time for assistance from staff after alerting	F 725	residents in the facility. Residents R7, R12, R18, R24, R37, R43, R44, R46 and R51 care plans were reviewed to ensure we are meeting their ADL needs. Then residents R15 and R33 care plans were reviewed that ensure we are meeting the needs of those residents to reduce any resident to resident altercations. R55 is deceased and R56 and R57 have been discharged from the facility. 2.We reviewed all residents care plans to ensure we sufficient staffing to meet the needs of all residents. This has the potential to affect all residents in our facility. 3.All nursing staff were in serviced on ADL care and supervision of the memory care unit by 12/29/2019 4.The staffing coordinator or designee will be responsible will be responsible for compliance. Audits will be completed daily x 1 month then weekly x 1 month then monthly x1. Results will be reviewed by our Quality committee for further recommendations.	

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

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F 725	Continued From page 84	F 725		

his call light. R44 stated facility staff issues would occur almost daily and was worse on the weekends.

NA-A was interviewed on 11/8/19, at 8:20 a.m. and confirmed R44 was waiting at least 30 minutes on the bedpan. NA-A stated they were "really far behind" getting residents up for the day due to only having two NAs when they should have had three NAs.

NA-J was interviewed on 11/8/19, at 8:25 a.m. and verified there were only two NA's and should have had three NAs. NA-J stated they were behind due to having been "down a staff" and indicated there were still five resident's left to get up out of bed.

The Staffing Director (SD) was interviewed on 11/8/19, at 9:01 a.m. and confirmed there were only two NA's working on the 200 unit instead of the needed three NAs. SD explained she was unable to find a nurse to work so the facility had to "pull" a NA to work as the trained medication aide which left only two NAs.

The director of nursing (DON) was interviewed on 11/8/19, at 1:06 p.m. and stated she expected staff to respond as promptly as they were able.

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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 85	F 725		

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 report indicated bathing "Not Applicable;"
-On 9/29/19, the report indicated bathing "Not Applicable;"
-On 10/13/19, the report indicated bathing "Not Applicable;"
-On 10/27/19, the report indicated independent with bathing;
-On 10/31/19, the report indicated bathing "Not Applicable;"
-On 11/7/19, after survey began, the report indicated extensive assist with bathing.

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 was interviewed on 11/6/19, at 8:32 a.m. and stated he "wants a shower." R43 was observed to have long 0.25 inch finger nails with brown dirt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 86	F 725		

underneath the nail, dirty clothing with food stains on them, and R43 was malodorous. R43 stated he had not had a shower in over two weeks and when he had requested no staff would come back to assist him.

NA-B was interviewed on 11/5/19, at 2:32 p.m. and verified R43 had not had a shower for three weeks. NA-B stated there were too many resident's whom required two people to provide cares and/ or transfers which would result in not enough staff to complete showers. NA-B explained in addition to residents whom required two staff there were also too many lifts which required two staff and resident's whom required constant behavior interventions for the staff to meet the resident's basic care needs. NA-B stated the staff had complained to the DON, however indicated nothing changed.

NA-C was interviewed on 11/6/19, at 8:41 a.m. and confirmed R43 had not had a shower in a while. NA-C explained "all the time the residents miss" their scheduled shower and the shower would be moved to the next day and/ or the next day due to not enough staff. NA-C indicated there was not time to look at updated resident care plans due to having been too busy. NA-C stated most days there were only two NAs for 30-32 residents and the staff did the best they could do just to complete incontinence care and/ or meet basic care needs of the residents. NA-C stated basic care was priority over showers. NA-C stated the staff had notified the DON they did not have enough staff to meet the resident care needs, however indicated no changes occurred.

Licensed practical nurse (LPN)-C was interviewed on 11/6/19, at 2:21 p.m. and stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 87	F 725		

on average the staff would work on the 200 unit with two NAs vs. three NAs and indicated showers would not get done as it was not realistic for two NAs to complete all of the basic cares on the unit. LPN-C confirmed residents would wait a long time for their call lights to be answered and indicated "we don't always have the DON and nurse manager answering lights" they did that due to state having been here.

DON was interviewed on 11/8/19, at 12:07 p.m. and stated it was her expectation for R43 to be showered per the shower schedule which was weekly. DON stated she expected a male staff to shower R43 per request and confirmed R43 had not been showered in the past two weeks. A subsequent DON interview was completed on 11/12/19, at 9:14 a.m. and stated the facility increased staffing on the weekend and was now all caught up showers.

NA-J was interviewed on 11/12/19, at 9:25 a.m. and stated there were not enough NAs and toileting and bathing/ showers would not get done. NA-J indicated three NAs were not enough due to acuity and care needs. NA-J stated the 200 unit needed four NAs to complete resident care timely.

The facility policy regarding toileting was requested, but not provided.

Resident Council
On 11/6/19, at 1:28 p.m. members of the resident council group met to review the facility resident council function. The following residents attended and provided the following information:
-R24 stated "nothing gets fixed" here we have had to wait a long time for call lights to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 88	F 725		

answered, however nobody did anything to follow-up with our concern;
-R12 stated residents had to wait a long time for call lights to be answered;
-R18 stated she had to wait a long time for staff assistance and indicated if you were in your room during meal times you would have to wait even "longer" for the call light to be answered. R18 stated staffing had gotten worse over the past couple of months;
-R37 stated wait time for staff assistance had increased during the past few months and at times he would not get showers due to not enough staff;
-R51 stated there were long wait times for call light response and indicated due to this staff were not always able to accommodate his choice regarding getting up at 4:30 a.m.
Resident council meeting minutes and response letters were reviewed 4/24/19, through 10/30/19, and revealed the following:
-The minutes dated 4/29/19, indicated a concern regarding call lights were not answered timely and residents felt ignored as staff were turning off their call light without responding to their request;
-A letter dated 5/7/19, in response to the resident council lacked evidence of call light and staff concerns;
-The minutes dated 5/29/19, indicated a concern regarding call lights not answered during meal times and call lights were still being turned off without providing the requested assistance;
-The minutes dated 6/26/19, indicated call lights not being answered timely, residents reported on average 45 minutes to one hour wait time. The minutes indicated call lights were still being turned off without assisting the resident. The minutes further indicated they were being told there was not enough staff and showers and/ or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 89	F 725		

baths were not being completed;
-The minutes dated 7/31/19, indicated residents were frustrated regarding no resolution and feeling as nothing was being done regarding the long call lights;
-The minutes dated 10/10/19, indicated 20 residents and five staff were in attendance and still no follow up on long call light wait times;
-The minutes dated 10/30/19, indicated concerns expressed regarding not enough staff during the overnight shift and still waiting for a response regarding long call lights wait times.

The ombudsman (OMB) was interviewed on 11/6/19, at 1:37 p.m. and stated there was repeated staffing issues. OMB stated residents complained there was not enough staff to meet their care needs and indicated the OMB reached out to DON a week ago regarding these concerns, however had not received a response.

The Facility Assessment reviewed 9/19/19, indicated the assessment was used to determine what resources were necessary to care for the residents competently during both day to day operations and emergencies. Staff were scheduled to ensure sufficient staff were able to meet the needs of the residents at any given time and further indicated staff patterns were adjusted based on census and acuity levels while providing appropriate support for the residents. The assessment indicated direct care staff- NA were to have had a 1:11 ratio on days/ evenings and 1:14 ratio during overnights in long term care. The assessment further indicated during the overnight there was to have been 1:50 ratio for nurses. Furthermore, the assessment identified assistance with activities of daily living in conjunction to the identified staffing ratios

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 90	F 725		

included transfer assistance for an independent resident range 1-26, one to two staff range of residents 1-20 and dependent resident range 1-20 and behavioral health needs resident range 1-20.

The staffing director (SD) was interviewed on 11/8/19, at 9:01 a.m. and stated the facility would staff one NA on the 100 unit, three NAs on the 200 unit and one NA on the 300 unit plus one nurse per unit on days/ evenings. SD stated on overnight shift there would be one NA per unit, one nurse for the 100 unit and one nurse for the 200 and 300 unit. During the interview SD verified the following staffing schedules and posted hours were reviewed 10/1/19, through 11/12/19, and revealed the following:
-On 10/4/19, the schedule indicated there were two NAs on the 200 unit, SD verified the NA ratio would have been 1:15 to 16;
-On 10/10/19, the schedule indicated from 4:00 a.m. until 6:00 a.m. the 200 unit NA covered both 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

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

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F 725	Continued From page 91	F 725		

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 assist due to behaviors and when the stand lift was used, however did not verify the actual number of residents.

During interview with medical director (MD) on 11/12/19, at 4:32 p.m. MD stated he attended the QAPI meetings and was aware some residents stated there is a long wait time with call lights to get staff response for assistance. MD stated discussion had been made regarding call light wait time and staffing. MD stated, "It was probably staffing not quite meeting the ratio and could be improved." MD stated he was not aware of any call light wait time audits being completed.

Call light audits were requested, but not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 92 Sufficient staffing policy request, but not provided. 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 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.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 93 -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 6:29 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 still activated. -At 6:31 p.m. R46 observed sitting in his w/c in his room waiting for assistance to bed with call light on. -At 6:33 p.m. no call lights activated in hall 200 -At 6:33 p.m. R46 observed still waiting in his room to go to bed. -At 6:38 p.m. R10 and R54's call lights came on over their room doors. -At 6:40 p.m. R46 wheeled himself out of his	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 725	Continued From page 94	F 725		

room into hallway looking down hallway. RN-A told R46 she could get R46 hooked up to the lift while he was waiting.
-At 6:44 p.m. R46 was observed sitting in his w/c in his room with RN-A present hooked up to the transfer lift.
-At 6:47 p.m. NA walked into R46's room to assist RN-A to transfer R46 to bed. (R46 waited 41 minutes for staff assistance).
-At 7:18 p.m. R46 stated to surveyor he wants to go to bed at 6:00 p.m. every evening. R46 stated he "waits that long all the time to go to bed, it's the usual."

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 bed. NA-B stated residents who needed less care at the last step of the process to bed went to bed first and the residents who required more steps last. NA-B stated there was not enough staff to wash residents up. NA-B stated that was generally the norm here at the facility.

LPN-C stated on 11/6/19, at 2:21 p.m. showers could not be completed when only having two NAs. LPN-C stated last Sunday only had two NAs and generally couple times a pay period ran with only two NAs instead of three NAs. LPN-C stated he cracked down on the NAs for turning off call lights before assisting resident. LPN-C stated R46 gets left to the end and staff leave tend to leave him and since R46 is patient R46 pays the price. LPN-C stated usually the DON and nurse manager aren't answering the call lights.

R46's care plan dated 11/7/19, did not include R46's preference for bedtime at 6:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 95	F 725		

RN-A nurse manager, stated on 11/7/19, at 2:26 p.m. R46 can go to bed at 6:00 p.m. and all staff knew that. RN-A stated R46's preference for bed time was not identified on R46's NA care sheet "as staff just know by word of mouth."

DON stated on 11/7/19, at 2:45 p.m. R46 could go to bed at 6:00 p.m. as it was his preference. DON stated staff should accommodate this and follow residents' careplan.

Facility policy Self Determination and Participation dated 7/25/16, indicated residents would be allowed to choose schedules that are consistent with their interest for daily routine including sleeping. The policy indicated to facilitate resident choices staff would gather information about residents' personal preferences upon initial assessment and periodically thereafter, and document these preferences in the medical record.

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.

R7 was observed on 11/4/19, at 6:55 p.m. sitting in his w/c near front desk. R7 stated he had to wait for help in the mornings to get his legs wrapped and get washed up. R7 stated night staff transferred him to his w/c at about 5 a.m.. R7 stated he asked the night nurse to wrap his legs at this time but the night nurse had told him she could not as she was too busy and the day nurse needed to wrap his legs. R7 stated he wanted his legs wrapped when he got up because his

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 96	F 725		

physician had told him it was better for his leg wound for his legs to be wrapped when getting up and the wound would heal faster.

R7's Annual MDS dated 8/1/19, indicated R7's cognition was intact and included a diagnosis of diabetes and anxiety. R7's Annual MDS indicated R7 needed extensive staff assistance with dressing and with all activities of daily living. R7's MDS indicated R7 did not reject cares.

R7's careplan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a venous ulcer on his lower right leg.

R7's physician order dated 11/7/19, indicated R7 was to have "Compression devices to bilateral lower extremities" applied daily related to Lymphedema (swelling 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.

R7 was observed on 11/7/19, at 8:07 a.m. sitting in his w/c in his room with his legs unwrapped, waiting for his call light to be answered. R7 stated the nurse had not yet wrapped his legs and stated his legs should be wrapped when he got up, and stated he had to go to the toilet and had been 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.

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

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F 725	Continued From page 97	F 725		

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 pad with drainage 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 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 legs today as was not time as was a lot to do and needed to pass the medications first.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 98	F 725		

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 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 nurse had told him she was "too busy" to wrap his legs.

R7's care plan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a venous ulcer on his lower right leg.

Director of Nursing (DON) stated on 11/8/19, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 99	F 725		

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.

Facility policy Accommodation of Needs dated 7/25/16, indicated, facility's staff behaviors should assist resident in maintaining and/or achieving independent functioning, dignity and well-being and accommodate residents' individual needs and preferences.

Facility policy Self Determination and Participation dated 7/25/16, indicated each resident should be allowed to choose schedules with times of days for treatments.

NA-J stated on 11/12/19, at 9:42 a.m. that Hallway 200 did not have enough NAs working at a time. NA-J stated three were scheduled on hallway 200 but three were not enough to get everything done that needed to be done on a shift. NA-J stated Hallway 200 needed almost four NAs on a shift. NA-J stated residents were not getting toileted timely and were not getting bathing and showering 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 100	F 725		

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.
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.

R15's Care Area Assessment dated 12/7/18, indicated R15 required a secured unit due to her wanting to leave the facility and her memory loss. R15 had severe cognitive impairment and was unable to focus on what others were saying and recall what was said.

R15's care plan printed on 11/6/19, indicated R15 had the potential to be physically aggressive related to dementia, and poor impulse control. R15 was bothered by loud noises. R15 was independent with ambulation and transfers. Interventions included: When R15 became agitated to intervene before agitation escalates,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 101	F 725		

and guide away from source; Monitor and document any signs of R15 posing danger to self or others; Staff to be aware of R15 activity on the unit and keep R15 from residents that tend to invade her personal space; Cue and supervise as needed; Redirect when R15 seems confused or at risk for doing something that might cause distress; Monitor pacing, wandering or crying occurrences.

Review of Daily Staffing Sheets since July of 2019, revealed that the 300 memory unit was staffed during day and evening shift with two staff and the night shift one staff.

Review of R15 resident to resident altercations Vulnerable Adult (VA) - Incident reports revealed that R15 had four altercations since July 2019, with physical aggression with other residents.
-On 7/27/19, R15 was able to place her hands around R57's neck, and then reach out to hit R56 in the arm before staff could intervene. Report indicated that constant awareness of other residents and their behaviors was key to keeping everyone safe and secure.
-On 9/19/19, R15 and R55 were identified as unsupervised when licensed practical nurse (LPN) heard screaming and swearing. When LPN got within eye sight she found R15 and R55 punching each other in the face. The report also indicated that the second staff was off the unit at the time of the altercation.
-On 10/11/19, R55 was sitting in his wheelchair near the exit door when R15 was observed to walk up behind R55 and rub his head. R55 was seen to get up from his wheelchair and starting pushing R15 before staff could intervene.
-On 10/22/19, R55 was sitting in his wheelchair and R15 walked up and leaned in and said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 102	F 725		

something to R55 then slapped him in the face with her open hand before staff could intervene.

On 11/4/19, at 1:17 p.m. R15 was observed sitting at the table in common area with no staff present. At 1:20 p.m. licensed practical nurse (LPN)-F entered the common area just as R15 got up and walked down the hall to go enter a room. The common area was unsupervised for three minutes where R15 was sitting.

On 11/4/19, at 5:21 p.m. R33 was observed sitting at a table yelling and R15 got up from her table walked over to R33 and stated something to her about a fist in your nose (unable to identify exactly what she said) then returned to her table. There were no staff present in the common area where these two residents were. At 5:25 p.m. kitchen staff entered the common area followed by a direct care staff. The common area was unsupervised for four minutes.

On 11/4/19, at 5:31 p.m. R15 was observed up walking around and stopped to play with a resident's hair who was sitting at the table. There was no staff present in the common area. There was an activity staff in the next room visiting with another resident but unable to visually see R15. At 5:39 p.m., the activity staff entered the common area where R15 was located. The common area was unsupervised for six minutes.

On 11/5/19, at 8:08 a.m. trained medication assistant (TMA)-A stepped out of a resident room and asked LPN-A for assistance. LPN-A left the common area where R15 was sitting and assisted the other staff. At 8:16 a.m., LPN-A returned to common area. The common area with residents sitting at tables and wheeling around

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 103	F 725		

were unsupervised for eight minutes. At 8:22 a.m. LPN-A left the common area where there were residents including R15. At 8:30 a.m., kitchen staff arrived to common area. The common area was unsupervised for eight minutes.

On 11/6/19, at 11:13 a.m. R15 was observed walking down the hallway and both staff were in another resident room. There was an activity staff in the common area but this staff was unable to visually see R15 and her whereabouts.

On 11/7/19, at 7:51 a.m. LPN-K left common area with residents (including R15) present to assist the other staff in a room. At 7:56 a.m, LPN-K returned to the common area having left the area unsupervised for five 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.

During interview on 11/4/19, at 5:25 p.m. NA-D stated that R15 always had aggressive behaviors and someone needed to watch her. NA-D stated that the nurse had medications to give on the memory unit and the 200 wing so that left NA-D alone at times and it was very hard to monitor everyone. NA-D stated that when she needs assistance with a resident the nurse was the one who helped and verifies that the residents were left unsupervised during those times.

During interview on 11/5/19, at 8:53 a.m. TMA-A indicated monitoring R15 included watching her as R15 was very keen on another male resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 104	F 725		

TMA-A stated "we cannot monitor all the residents when we are in getting residents up" and that was a safety concern.

The activity director (AD) was interviewed on 11/6/19, at 10:20 a.m. and stated that the activity department did not have set hours on the memory unit. AD stated the activity staff were not called to assist with monitoring residents on the memory unit while staff were completing cares as it was not part of the activities daily duties.

The assistant director of nursing (ADON) was interviewed on 11/6/19, at 10:45 a.m. and indicates that R15 had quite a few incidents when she lashed out unprovoked. ADON stated staff kept an eye on R15, and R15 was supposed to be always in eye sight of staff. ADON stated if staff need to be in a room and could not monitor the common area they needed to radio for someone to come, as there needed to be someone monitoring at all times as there were other residents with behaviors. ADON agreed that R15 continued to have resident to resident altercations with no resolution. ADON stated she was unsure if anyone had looked at the times the altercation happened to see if there was a pattern.

During interview on 11/6/19, at 11:12 a.m. DON indicated R15 was to be monitored but was not on one to one supervision as the facility did not have those resources. DON stated there were residents on that unit that required two staff assistance and during those times staff had to radio call for assistance to monitor residents in the common area. DON stated it was her expectation that residents were not left alone in the common area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 725	Continued From page 105 On 11/6/19, at 2:09 p.m. RN-A indicated there should have always been one staff within eyes view of the hall and common area ideally. RN-A stated there were times that did not happen as the nurse went to give pills but that was why staff carried radios so they can ask for help. On 11/7/19, at 8:45 a.m. licensed social worker stated staff were expected to be with R15 when she was in the common area. On 11/7/19, at 3:13 p.m. NA-I stated someone had to watch the residents when they were in the common area at all times because "you never know what they will do." Review of undated, Resident to Resident Altercation policy identified staff were to monitor residents for aggressive or inappropriate behaviors towards others. Review of the 9/27/19, Abuse Policy and Procedure indicated staff were to institute measures to address the needs of residents to minimize the possibility of abuse. The Abuse Prevention Program section indicated staff were committed to protect residents from abuse. The policy also indicated staff will identify occurrences and patterns of potential abuse and implement changes to prevent future occurrences.	F 725		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 730		12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 730	Continued From page 106 education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document 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 of 5/19/17. E3's personnel file revealed E3 was a NA who had worked at the facility over a year. E3's file revealed no 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.	F 730	1.It is the expectation that annual performance evaluations are to be done on all employees. 2.Performance evaluations will be current for the nursing staff by 12/29/2019. 3.This has the potential to affect all facility residents 4.The director of nursing or designee will be responsible for compliance. Audits will be done weekly x 2 months and then monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 107	F 740		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions regarding resident to resident behaviors for 2 of 2 residents (R43, R27) reviewed for resident to resident altercation. Findings include: R43 was observed on 11/4/19, at 6:55 p.m. seated in his w/c calm and alert. R43 was interviewed and stated about a month ago R27 threatened him when R27 held his cane into the air and yelled at him. R43 stated after R27 threatened him, the facility still had R43 and R27 move in together as roommates despite R43's expressed concerns to the director of social services (DSS). R43 explained shortly after he and R27 became roommates R27 was upset about R43's TV having been too loud and while R43 was seated in his wheelchair (w/c) R27 attempted to hit him with his cane in his head. R43 used his hand to cover his head. R43 stated	F 740	1.We completed mood and behaviors assessments for both residents R27 and R43. their care plans were reviewed and updated to reflect current interventions for mood and behaviors. 2.This has a potential to affect all residents in our facility. All current residents have been reviewed for current mood and behavior assessments and reassessed as needed. Care plans reviewed and updated to reflect current mood and behavior needs. 3.Social service director and all nursing staff were in serviced on the facility policy for mood and behavior assessments and interventions on 12/20/2019, 4.Social service director or designee will be responsible for compliance. Audits will be completed weekly x 4, then monthly x 2. Results will be reviewed by our Quality committee for further recommendations	12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 108	F 740		

he sustained a laceration to his hand from R27's cane. R43 stated after R27 hit him R43 was moved to a new room.

Family member (FM)-B was interviewed via telephone on 11/5/19, at 10:33 a.m. and stated R43 was not getting along with other residents and indicated R43 had to call the police due to another resident whom hit R43 with a cane. FM-B stated the facility staff would tell her R43 was the "trouble person" and was told by the facility staff to "deal with it."

R27 was interviewed on 11/6/19, at 1:07 p.m. and stated R43 made a false allegation against R27 accusing R27 of hitting R43 with his cane and threatening him. R27 stated it was him whom had been threatened by R43. R27 stated he notified the director of nursing (DON) regarding R43's threats, however said nothing had changed. R27 was observed seated on the edge of his bed with his cane near the wall of the bed. R27 indicated he would sleep with his cane in his bed.

FM-A was interviewed via telephone on 11/8/19, at 9:44 a.m. and stated R27 called her last weekend and stated "he was in fear for his life" and R27 had to sleep in the chapel due to having been "afraid of others." FM-A indicated she came to visit R27 over the weekend and brought R27 a beer due to R27 having been a "chronic alcoholic and he use to do a lot of street drugs in his day." FM-A stated she thought R27 would do better if he could drink at least daily.

R43's annual Minimum Data Set (MDS) dated 10/3/19, identified R43 had intact cognition and diagnoses which included anxiety and depression. The annual MDS indicated R43 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 740	Continued From page 109	F 740		

verbal behavioral symptoms directed toward others one to three days during the reference period and indicated R43's behavioral symptoms did not impact others.

R43's Cognitive Loss Care Area Assessment (CAA) dated 10/15/19, identified R43 had a guardian due to poor life choices and indicated R43 made poor decisions not good for his health. R43's Mood State CAA dated 10/15/19, indicated R43 would try to get along with other residents and would adjust to his new roommate. R43's Behavioral Symptoms CAA dated 10/15/19, indicated R43 would not tell at other residents.

R43's Care Plan revised 10/23/19, identified R43 was intolerant of residents and visitors who did not demonstrate behaviors whom align with R43's values and directed staff to encourage R43 to make own decisions, increase communication between resident and family about care and living environment, provide opportunities for R43 to participate in care, R43 needs encouragement to identify problems that cannot be controlled and potential solutions to present problems and when conflict arises remove R43 to a calm safe environment and allow to vent and share feelings.

R43's Admission Record dated 11/8/19, indicated R43 had diagnoses which included adjustment disorder with mixed anxiety and depression, opioid abuse and psychoactive substance abuse.

R43's Progress Notes (PN) were reviewed from 9/15/19, through 11/7/19, and revealed the following:
-The PN dated 9/20/19, indicated R43 had "an extreme outburst" and was "screaming out profanities at staff and other residents ...The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 110	F 740		

writer and the LSW [licensed social worker] were unable to calm him down. I informed him that I had no choice but to call the police." The PN indicated when the police arrived R43 had calmed down and apologized for his behavior;
-The PN dated 9/21/19, indicated R43 and another resident were arguing and used "profanity during dinner" both parties were in the dining room shouting at each other "writer" was able to redirect;
-The PN dated 9/25/19, indicated R43 asked his roommate a question and his roommate told R43 "to F*** off ...writer told both residents they were out of line. Roommate went back into the facility while" R43 stayed outside;
-The PN dated 9/26/19, indicated R43 was issued a room change notification guardian requested a full seven days before moving R43;
-The PN dated 9/27/19, indicated R43 and roommate yelled at each other in their room, staff intervened as soon as yelling was heard. "Resident is very agitated;"
-The PN dated 10/4/19, indicated R43's guardian was upset R43 had to move again and did not think this was fair. The facility indicated R43 had had three roommates and had not treated them in a respectful manner;
-The PN dated 10/7/19, indicated R43 "started" to swing out at staff and wheeled self into the hallway then fell asleep;
-The PN dated 10/10/19, indicated "late entry for 9/27/19," and identified "writer" went into R43's room as soon as yelling was heard upon entering the room R43 indicated his roommate took his TV remove R43 was flailing his arms and his roommate was seated on his bed. The PN indicated R43 had blood on his left hand and R43 stated his roommate hit him with his cane. "This writer does not know how that was possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 111	F 740		

Roommate's cane was laying next to the wall on his bed ...with privacy curtain pulled between them;"
-The PN dated 10/13/19, indicated suspicion of illicit drug use and marijuana paraphernalia had been found and R43 confirmed that he used it;
-The PN dated 10/31/19, indicated R43 was asked not to "harass" R27. R43 started to make comments about when R43 and R27 were roommate's writer left room to let R43 calm down follow up as needed.

R43's medical record lacked evidence of comprehensive assessment, development of interventions and ongoing monitoring of behaviors and issues with other residents.

R27's annual MDS dated 9/9/19, identified R27 had intact cognition and diagnosis which included dementia. The annual MDS indicated R27 had no behavioral symptoms during the reference period.

R27's Psychosocial Well-Being CAA dated 9/18/19, indicated R27 had a new roommate whom talked a lot.

R27's Care Plan revised on 10/14/19, identified R27 had psycho-social wellbeing problem related to anxiety, inability to problem solve, social isolation and directed staff to encourage participation from R27 to make own decisions, support and encourage realistic goals, when conflict arises remove R27 to a calm safe environment and allow to vent and share feelings.
R27's care plan initiated on 11/2/19, identified R27 reported disagreements with other residents, history of current verbal altercations and making threats to hurt other residents and directed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 112	F 740		

to observe periodically to ensure safety, remove from dangerous situations and redirect when confused or at risk for doing something that might cause distress.

R27's Admission Record dated 11/8/19, indicated R27 had a diagnosis of alcohol abuse.

R27's PN were reviewed 9/12/19, through 11/7/19, and revealed the following:
-The PN dated 9/17/19, indicated R27 reported his roommate became verbally aggressive towards him and feels unsafe in current room. R27 was moved to a new room;
-The PN dated 9/25/19, indicated R27 moved into a new room and was having had "difficulties" adjusting to each other;
-The PN dated 9/27/19, indicated R27 and his roommate were yelling at each other and R27 did not want to stay there due to not trusting him;
-The PN dated 10/10/19, indicated "Late entry for 9/27/19, yelling was heard from residents room and upon enter the room R27's roommate was very agitated and R27's roommate indicated R27 hit him with his cane. The PN indicated R27's cane was lying next to the wall on his bed with the privacy curtain between and "writer does not know how that possible;"
-The PN dated 10/12/19, indicated R27 was "short tempered with staff;"
-The PN dated 10/31/19, indicated R27 reported he had a verbal altercation with his new roommate. A subsequent PN dated 10/31/19, indicated R27 showed "some aggression" in the hall towards staff and indicated R27 and his roommate had an issue over the TV. The PN indicated R27 was going to hit whoever got in his way and was encouraged to give his new roommate a chance, however R27 indicated "he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 113	F 740		

would take his cane and hit anyone who got in his way;"
-The PN dated 11/1/19, indicated R27 was found lying on the floor of the chapel due to his roommate having "physically threatened" R27 indicating "they would beat ...me" and called R27 names. The PN indicated R27 did not want to return to his room and remained in common areas of the facility for the rest of the overnight. The PN indicated the DON and nurse manager were notified of incident;
-The PN dated 11/2/19, indicated R27 slept in the chapel "again" and had been going in and out of his room, however avoiding conversation with staff. R27 encouraged to sleep in his bed, however R27 declined and wheeled away. A subsequent PN dated 11/2/19, indicated R27's provider was updated regarding R27's behaviors of threatening others and refusing to have gone into his room;
-The PN dated 11/3/19, indicated at 11:45 p.m. R27 was found seated in the chapel. R27 "seem confused and paranoid." R27 indicated he was not going back into his room until his roommate was not there. R27's roommate transferred to a different room and R27 returned to his room.

R43's medical record lacked evidence of comprehensive assessment, development of interventions and ongoing monitoring of behaviors and issues with other residents.

DSS was interviewed on 11/6/19, at 10:57 a.m. and stated R43 and R27 were seated out front of the building and the DSS was present when R43 and R27 had a verbal disagreement. DSS indicated she talked with R43 and R27 regarding about the need to "get along." DSS stated she updated the nurse to "watch them" since they did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 114	F 740		

not "seem to get along." The DSS stated after that R43 accused R27 of hitting him with his cane, however did not think the incident occurred. The DSS further explained R43 had previous roommates he did not get along with as well as R27 had roommate issue prior to R43 and after. DSS stated R27 had a new roommate after R43 that he had issues with as well and was sleeping in the chapel due to the issues.

Nursing assistant (NA)-A was interviewed on 11/6/19, at 1:54 p.m. and stated R27 had a history of confrontation with his roommates and indicated R27 would leave his room and refuse to return to his room when he felt threatened.

Licensed practical nurse (LPN)-B was interviewed on 11/8/19, at 7:50 a.m. and stated she had been working the night R43 accused R27 of hitting him with his cane over the TV. LPN-B stated she heard R43 and R27 yelling back and forth, however was unable to verify if R27 did or did not hit R43 with his cane.

Registered nurse (RN)-A was interviewed on 11/8/19, at 10:22 a.m. and reviewed R43's and R27's care plans and verified both care plans were not updated following behaviors and issues with other residents. RN-A confirmed R43's care plan lacked evidence of possible substance use.

DON was interviewed on 11/8/19, at 12:14 p.m. and stated it was her expectation to re-evaluate and update the resident's care plan when there was a noted change in behavior and/ or continued threats between residents.

The facility Behavioral Assessment, Intervention and Monitoring Policy undated, indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 115 residents would have had minimal complications associated with the management of altered or impaired behavior. The policy indicated appropriate assessment and treatment of behavioral symptoms required differentiating between behavioral symptoms that could be managed by treating underlying factors and those that cannot. The policy indicated part of the comprehensive assessment staff would evaluate based on input from the resident, family and caregivers, review of medical record and general observations which would include resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers. The nursing staff would identify and document any precipitating or relevant factors. The interdisciplinary team (IDT) would thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition. The care plan would incorporate findings from the comprehensive assessment which would be consistent with current standards of practice. Interventions would be individualized and part of an overall care environment to prevent or relive the residents distress. The IDT would monitor the progress of the individuals behavior until stable and interventions would be adjusted based on the impact on behavior.	F 740		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.	F 744		12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 116 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 "being physical" and "rough" with R41. NA-B explained R41 was asking not to be touched and LPN-A continued on and "man handled" R41 as R41 was "begging not to touch" her. NA-B stated R41 repeatedly yelled "leave me alone leave me alone" as R41 tightened her arms inward, however NA-B indicated LPN-A did not stop. NA-B indicated LPN-A asked NA-D to assist with changing R41 out of urine soaked clothing and both LPN-A and NA-D continued "manhandling" R41 while "pulling her clothes off against her will." DON explained R41 had a history of having been resistive to cares, however staff were to give R41 time and reapproach. R41's quarterly Minimum Data Set (MDS) dated 8/26/19, identified R41 had severe cognitive impairment and diagnoses which included dementia and Parkinson's disease. R41's quarterly MDS indicated R41 required extensive staff assistance with activities of daily living (ADL). The MDS further indicated R41 had no behaviors during the reference period, however	F 744	1.Nursing and Social Services will reassess resident for psychosocial needs and add personalized behavioral interventions to minimize the anxiety that is displayed during cares. R41 and family will be included in interventions on the care plan. Nursing and Social Services will reassess residents that display behaviors to ensure personalized behavioral interventions are in place. 2.This has the potential to affect all facility residents. All current residents have been reviewed for current mood, behavior and psychosocial assessments and reassessed as needed. Care plans reviewed and updated to reflect current mood, behavior and psychosocial needs. 3.Nursing Staff, licensed social worker and MDS Coordinator will be provided education on personalized behavior care plan interventions 4.The director of nursing or designee will be responsible for compliance. Audits will be done daily x 4 weeks then monthly x 2. Results will be reviewed by our Quality committee for further recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 117	F 744		

did reject cares one to three days.

R41's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 6/3/19, identified R41 thought staff were trying to hurt her and "only wishes" her husband care for her. R41's CAA directed staff to continue to work with R41 to gain acceptance and help R41 with ADLs. R41's Behavioral Symptoms CAA dated 6/3/19, identified R41 had dementia and did not understand staff were trying to help and R41 would refuse to let staff help her. The CAA indicated R41 would adjust to staff helping her with her cares.

R41's Care Plan dated 5/31/19, identified R41 was dependent on staff for meeting physical and emotional needs and R41 would benefit from one to one's as R41 loved to talk of her grandson and enjoyed being read to. R41's care plan directed staff to converse with R41 while providing cares and encourage family involvement. R41's care plan revised 9/9/19, identified R41 had potential to hit others and directed staff to assess and address contributing sensory deficits and when R41 became agitated intervene before escalates, guide away from source of distress, engage calmly in conversation, if response was aggressive staff were to walk calmly away and approach later. The care plan identified R41 would tell staff to get out and directed staff that R41 tolerates two people at a time and provide one foot of personal space and R41 reacted to touch by telling staff to get away. The care plan further identified R41 had communication problem and directed staff to anticipate and meet needs, allow adequate time to respond, repeat as necessary, do not rush, request clarification from R41 to ensure understanding, face when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 118	F 744		

speaking, make eye contact, reduce environmental noise, as yes/no questions, use simple brief consistent words/ cues, discuss with R41 and family concerns regarding communication difficulty, encourage R41 to state thoughts focus on a word or phrase that makes sense, monitor/ document frustration level wait 30 seconds prior to providing R41 with word and validate R41's message by repeating aloud.

R41's Progress Notes (PN) were reviewed 10/10/19, through 11/6/19, and revealed the following:
-The PN dated 10/12/19, indicated R41 refused to bathe;
-The PN dated 10/16/19, indicated R41 refused bedtime cares from her husband and when staff attempted R41 refused several times, R41 also refused bedtime time medications as well;
-The PN dated 10/26/19, indicated R41 refused morning medications after three attempts;
-The PN dated 10/31/19, indicated R41 refused to be toileted by staff and "eventually" allowed staff to toilet her.

R41's medical record lacked evidence of comprehensive reassessment of R41's behaviors and current effectiveness of current personalized behavior interventions.

R41 was interviewed on 11/7/19, at 6:49 a.m. and was unable to answer questions. During that time R41 was observed in bed eyes open mumbling to self with a calm relaxed demeanor.

R41 was observed on 11/7/19, at 7:37 a.m. and assisted with morning cares from NA-C and Registered nurse (RN)-A. NA-C told R41 "we are going to get you up" R41 replied "oh God no."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 744	Continued From page 119	F 744		

NA-C and RN-A continued to proceed and assisted R41 to sit in the edge of her bed and placed slippers as R41 sat on the bed R41 stated "oh come on now, oh God no oh come on now" NA-C placed transfer belt around R41 and RN-A moved R41's walker in front of her. R41 independently began to place her hands onto the walker as she continued to repeat "oh God no, come on, oh God no." RN-A verbally cued R41 to walk into the bathroom and offered R41 to sit onto the toilet. NA-C and RN-A stood near R41 with one hand each on R41's transfer belt and assisted R41 to stand R41 walked with walker calmly into the bathroom.

NA-C was interviewed on 11/7/19, at 8:04 a.m. and stated R41 was "normally" not that calm. NA-C explained R41 would normally be resistive especially when she was rushed and would yell out the entire time staff would attempt to provide cares. NA-C stated staff were to reapproach and/ or ask for help when R41 was yelling and refusing cares. NA-C stated reapproaching would not always work for R41. NA-C indicated there were times there was not a second person available to assist and ensure R41 had two people for cares and during these times R41 would yell and repeat statements.

LPN-A was interviewed via telephone on 11/7/19, at 1:01 p.m. and stated one night when she checked on R41 LPN-A found R41 awake and wet from urine. LPN-A stated R41's sheets were wet from her knees up her back and indicated LPN-A was by herself attempting to get R41 up to assist R41 to get changed. LPN-A stated R41 kept "telling me no she was cold." LPN-A explained she was "trying to get her clothes off faster" and as an NA walked by LPN-A asked for

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

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F 744	Continued From page 120 help. LPN-A stated R41 was resistive and complaining she was cold and was yelling due to wanting to get back into bed. LPN-A stated "usually" you just reapproach R41 and try again, however sometimes that did not work. LPN-A stated she was focused that R41 was wet and cold and was working to keep R41 warm and get her out of the wet clothing and back into bed. LPN-A stated she and the NA continued to work and positioned R41 back into bed. DON was interviewed on 11/8/19, at 12:21 p.m. and stated it was her expectation staff were to follow the resident care plan, evaluate and monitor the effectiveness of interventions and update the care plan as needed. The facility Dementia- Clinical Protocol undated, indicated for individual with dementia the interdisciplinary team (IDT) would identify a resident-centered care plan to maximize remaining function and quality of life. The policy indicated IDT would adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes.	F 744		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		12/29/19

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F 755	Continued From page 121 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate narcotic documentation for 6 of 7 (R23, R25, R26, R36, R45, R51) residents. Additionally, the facility failed to ensure a minimum of daily reconciliation of narcotic counts on two days during October and November, 2019. In addition, the facility failed to ensure narcotics were reconciled and destruction was monitored and documentation maintained for 1 of 1 resident (R32) reviewed for medication administration. Findings include:	F 755	1.R23, R25, R26, R36, R45 and R51 will have a comprehensive record review with comparison of the EMR to the bound narcotic book. Missed doses will have medication error report filled out. A root cause analysis will be done to help determine the cause of inaccurate narcotic documentation. The nursing staff are expected to count at the beginning and end of their shift to ensure all controlled substances are accounted for. R32 is deceased. The missing bottles of morphine were reported on the Nursing	

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 122 R23 R23's Minimum Data Set (MDS) identified diagnoses that included lymphedema and pain in her right leg and had significant cognitive impairment. R23's medication administration record (MAR) indicated R23 was prescribed hydrocodone-acetaminophen 5-325 milligrams (mgs) every six hours for pain. On 10/23/19, R23 had three doses of oxycodone signed out by nursing staff in the narcotic sign-out book for R23, however four doses were documented in R23's MAR. On 10/24/19, five doses were signed out with the fifth (last) dose dated 10/24/19, identified as being the 2:00 a.m. dose. The next three doses signed out in the narcotic log were dated 10/25/19, for the usually scheduled doses for 7:00 a.m., 1:00 p.m., and 7:00 p.m. It appeared the fifth dose signed out on 10/24/19, was dated incorrectly and was actually the 2:00 a.m. dose for 10/25/19. These discrepancies were verified by licensed practical nurse (LPN)-D during an interview on 11/8/19, at 10:12 a.m. and by the director of nursing (DON) on 11/8/19. R25 R25's MDS dated 9/11/19, identified diagnoses that included fractures in left foot, end stage liver disease, cirrhosis, and ascites. It indicated R25 was cognitively intact. R25's MAR indicated R25 was prescribed 5 mg of oxycodone every six hours for pain. On 10/29/19, one dose of oxycodone was signed	F 755	Home Incident Reporting site, the Cannon Falls Police Department was notified and came to the facility to investigate. Nursing staff have been interviewed. The medications are unaccounted for (1 ml of morphine and 8 ml of morphine). 2.This has the potential to affect all facility residents. All current medication for current residents was reviewed to ensure all medication is here and accounted for. 3.Education will be provided on medication administration including the entire process of ordering, receiving, dispensing, documentation and destruction of controlled substances, documentation requirements in the EMR, narcotic book and signature book indicating reconciliation was done at each shift change by 12/29/2019 4.The director of nursing or designee will be responsible for compliance. Audits will be done daily x 4 weeks, weekly x 1 month and monthly x 1. Results will be reviewed by our Quality committee for further recommendations	

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 755	Continued From page 123	F 755		

out in the narcotic sign-out book, however, two doses were documented in R25's MAR. This discrepancy was verified by LPN-E during an interview on 11/12/19.

R26
R26 resided on a secured memory unit with diagnoses including arthritis of the knee, low back pain, and unspecified pain, according to admission record dated 7/10/18.

Per physician orders dated 11/12/19, R26 was to receive the medication oxycodone (a narcotic pain medication) five mgs four times per day for pain.

On 11/12/19, at 09:19 a.m. the required narcotic administration tracking book for R26 was reviewed with Trained Medication Aide (TMA)-A. A discrepancy appeared to exist when it was noted administered scheduled medications had not been registered in the narcotic sign-out book. On further investigation, R26 had 2 separate cards of pills and 2 separate pages for documentation, one page for each card of pills.

R36
R36's provider order summary printed 11/12/19, indicated diagnoses included chronic pain syndrome, persistent fracture of left humerus, several pressure ulcers, and quadriplegia. The summary indicated R36 was prescribed oxycodone 15 mg every four hours for chronic pain.

On 10/16/19, two doses of oxycodone were entered into the narcotic sign-out book, but four doses were documented as given in R36's MAR with two doses were blank. On 10/17/19, the 4:00

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 755	Continued From page 124	F 755		

p.m. and 10:00 p.m. doses were signed out, but there were three doses documented at 4:00 p.m., 6:00 p.m., and 10:00 p.m.. There were three doses left blank. On 10/19/19, four doses were signed out and all six scheduled doses were documented in the MAR.

During an interview on 11/12/19, at 9:45 a.m. LPN-E verified all these discrepancies in both records.

R45
R45's MAR indicated R45 was prescribed oxycodone five mgs three times per day. On 11/1/19, 11/5/19, 11/6/19, and 11/7/19, R45 had oxycodone five mg doses signed out of the narcotic log two times each day. However, three doses were documented in R45's MAR for each of those days. The director of nursing (DON) verified these discrepancies during an interview on 11/8/19, at 9:24 a.m..

R51
R51's MAR indicated R51 was prescribed hydromorphone one mg every four hours for chronic respiratory failure with hypoxia. On 10/14/19, and 10/15/19, four doses were signed out in the narcotic sign-out book, but six doses were documented in R51's MAR. On 10/16/19, and 10/17/19, five doses were signed out and six doses were entered in the MAR. The DON verified these discrepancies during an interview on 11/8/19, at 9:24 a.m..

The three current narcotic reconciliation logs were reviewed on 11/6/19, at 1:05 p.m. to verify accurate practice for reconciling the narcotic counts. It was noted that there were more than 100 missing signatures on shifts with no

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	245304	A. BUILDING _____ B. WING _____	C 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

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F 755	Continued From page 125	F 755		

signatures. The narcotic log for station 300 showed from 10:00 p.m. on 9/27/19, to 2:00 p.m. on 9/28/19, totaling 40 hours, there were no signatures for 40 hours. Additionally, from 6:00 a.m. on 10/18/19, to 10:00 p.m. on 10/9/19, there were no signatures indicating narcotic medication reconciliation was completed.

DON verified these missing signatures on the narcotic count on 11/8/19, at 9:45 a.m. and indicated it was the expectation that they should be counted at the end of every shift.

The administrator was interviewed on 11/12/19, at 12:40 p.m. and confirmed there were no formal audits of narcotic use and or documentation.

The consultant pharmacist (CP) was interviewed on 11/12/19, at 2:55 p.m. and stated he was aware of the narcotic diversion but did not know any specifics. CP indicated that he attended the quarterly quality council meeting once each quarterly and is scheduled for next week. CP stated narcotics were refilled on demand, but were required to have a provider order and that only two months could be ordered at a time. Typically, only one month or less of narcotic prescription was sent at a time. The pharmacist indicated that there was a 10% audit process included in the pharmacy services, but the facility could contract for a more robust service.

The facility's Controlled Substances policy revised 8/2/19, indicated that nursing staff "must count controlled medications at the end of each shift". A nurse going off the shift and a nurse coming on duty must make the count together and document and report any discrepancies to the DON.

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

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F 755	Continued From page 126	F 755		

R32's annual MDS dated 9/19/19, indicated R32 had intact cognition and diagnoses which included anxiety, asthma, chronic obstructive pulmonary disease or chronic lung disease. The annual MDS indicated R32 had frequent pain and received opioid seven out of seven days.

R32's Order Summary Report dated 11/12/19, included morphine sulfate solution every one hour as needed for pain and/or shortness of breath.

R32's Individual Narcotic Record was reviewed 5/1/19, through 11/12/19, and revealed the following:
-R32's morphine sulfate (narcotic schedule II controlled substance) dated 5/17/19, at 12:42 p.m. indicated 8.00 milliliters (ml) remained, however R32's medical record lacked evidence regarding further account for the 8.00 ml of morphine sulfate;
-R32's morphine sulfate dated 10/26/19, at 5:51 p.m. indicated 5.75 ml remained;
-R32's morphine sulfate dated 10/31/19, no time noted indicated "remeasured" 1.00 ml remained, however R32's medical record lacked evidence regarding account for the 4.75 ml from 10/26/19, to 10/31/19, and further lacked evidence of the account of the remaining 1.00 ml..

R32 was interviewed on 11/12/19, at 9:16 a.m. and stated his pain was "good" and denied shortness of breath.

R32 was observed on 11/12/19, at 9:16 a.m. calm and no signs of pain and/or shortness of breath.

LPN-D was interviewed on 11/12/19, at 10:16 a.m. and verified she was unable to locate R32's

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	245304	A. BUILDING _____ B. WING _____	C 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

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F 755	Continued From page 127	F 755		

morphine sulfate dated 5/17/19, with 8.00 ml and 10/31/19, with 1.00 ml remaining. LPN-D stated she was unsure what happened from 10/26/19, to 10/31/19, regarding R32's 4.75 ml of morphine sulfate.

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.

The consultant pharmacist was interviewed via telephone on 11/12/19, at 2:57 p.m. and stated per the board of pharmacy it was expected for two individuals at the facility destroy narcotics together and a "paper trail" should have been kept for a minimum of two years.

The facility Controlled Substances policy updated 8/2/19, indicated the facility would comply with all laws, regulations and other requirements related to handling, storage, disposal and documentation of schedule II and other controlled substances. The policy indicated nursing staff must count controlled medications at the end of each shift, the nurse coming on duty and the nurse going off duty must make the count together. DON would investigate any discrepancies in narcotic reconciliation to determine the cause and consult the pharmacy and administrator to determine any needed legal action. The facility Discarding and Destroying Medications policy adopted 8/12/19,

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 755	Continued From page 128 indicated medications would be disposed in accordance with federal and state regulations. The policy indicated all unused controlled substances would be retained in a securely locked area with restricted access until disposed of. The policy indicated disposal of controlled substances must have taken place immediately no longer than three days after discontinued. Following medication destruction a disposition record would include reason for disposition, method and witness signature. The medication disposition record would have been kept on file for two years.	F 755		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This 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. Findings include: On 11/6/19, at 1:28 p.m. members of the resident council group met to review the facility resident	F 835	1.It is facility policy to ensure we are utilizing facility resources with respect to sufficient staffing ratios to promote the resident's highest practicable physical and mental function and well-being. 2.This has the potential to affect all residents in our facility. 3.The facility has reviewed the facility assessment to ensure we have sufficient staffing to meet the needs of our residents on 12/18/2019. We reviewed acuity to ensure or staffing was sufficient 4.The administrator or designee will audit to ensure compliance with sufficient	12/29/19

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	245304	A. BUILDING _____ B. WING _____	C 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

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F 835	Continued From page 129 council function. The following residents attended and provided the following information: -R24 stated "nothing gets fixed" here we have had to wait a long time for call lights to get answered, however nobody did anything to follow-up with our concern; -R12 stated residents had to wait a long time for call lights to be answered; -R18 stated she had to wait a long time for staff assistance and indicated if you were in your room during meal times you would have to wait even "longer" for the call light to be answered. R18 stated staffing had gotten worse over the past couple of months; -R37 stated wait time for staff assistance had increased during the past few months and at times he would not get showers due to not enough staff; -R15 stated there were long wait times for call light response and indicated due to this staff were not always able to accommodate his choice regarding getting up at 4:30 a.m. Resident council meeting minutes and response letters were reviewed from 4/24/19, through 10/30/19, and revealed the following: -The minutes dated 4/29/19, indicated a concern regarding call lights were not answered timely and residents felt ignored as staff were turning off their call light without responding to their request; -A letter dated 5/7/19, in response to the resident council lacked evidence of call light and staff concerns; -The minutes dated 5/29/19, indicated a concern regarding call lights not answered during meal times and call lights were still being turned off without providing the requested assistance; -The minutes dated 6/26/19, indicated call lights not being answered timely, residents reported on	F 835	staffing. Audits will be completed daily x 1-month, weekly x 4, then monthly x 1. Results will be reviewed by our Quality committee for further recommendations.	

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

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F 835	Continued From page 130	F 835		

average 45 minutes to one hour wait time. The minutes indicated call lights were still being turned off without assisting the resident. The minutes further indicated they were being told there was not enough staff and showers and/ or baths were not being completed;
-The minutes dated 7/31/19, indicated residents were frustrated regarding no resolution and feeling as nothing was being done regarding the long call lights;
-The minutes dated 10/10/19, indicated 20 residents and five staff were in attendance and still no follow up on long call light wait times;
-The minutes dated 10/30/19, indicated concerns expressed regarding not enough staff during the overnight shift and still waiting for a response regarding long call lights wait times.

The resident council meeting minutes and response letters lacked evidence of follow-up related to continued concerns of long call light wait times.

The ombudsman (OMB) was interviewed on 11/6/19, at 1:37 p.m. and stated there was repeated staffing issues. The OMB stated residents complained there was not enough staff to meet their care needs and indicated the OMB reached out to the director of nursing (DON) a week ago regarding these concerns, however had not received a response.

The administrator was interviewed on 11/12/19, at 2:18 p.m. and verified each department head was responsible to follow up on each identified concern from resident council.

During the survey 11/4/19, through 11/12/19, the following areas of concern were identified:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 131	F 835		

See F561: 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.

See F677: 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).

See F725: Based on observation, interview and document review, the facility failed to ensure sufficient staff were available to meet resident needs for 4 of 5 residents (R44, R43, R46, R7) dependent on staff for activities of daily (ADLs) and for 5 of 9 residents (R24, R12, R18, R37, R51) whom expressed concerns during resident council meeting. In addition, the facility failed to provide supervision to reduce resident to resident altercations for 5 of 5 residents (R15, R33, R55, R56, R57) in the memory unit.

The Facility Assessment reviewed 9/19/19, indicated the assessment was used to determine what resources were necessary to care for the residents competently during both day to day operations and emergencies. Staff were scheduled to ensure sufficient staff were able to meet the needs of the residents at any given time and further indicated staff patterns were adjusted based on census and acuity levels while providing appropriate support for the residents. The assessment indicated direct care staff- NA were to have had a 1:11 ratio on days/ evenings and 1:14 ratio during overnights in long term care. The assessment further indicated during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 132	F 835		

overnight there was to have been 1:50 ratio for nurses. Furthermore, the assessment identified assistance with activities of daily living in conjunction to the identified staffing ratios included transfer assistance for an independent resident range 1-26, one to two staff range of residents 1-20 and dependent resident range 1-20 and behavioral health needs resident range 1-20.

The staffing director (SD) was interviewed on 11/8/19, at 9:01 a.m. and stated the facility would staff one NA on the 100 unit, three NAs on the 200 unit and one NA on the 300 unit plus one nurse per unit on days/ evenings. SD stated on overnight shift there would be one NA per unit, one nurse for the 100 unit and one nurse for the 200 and 300 unit. During the interview SD verified the following staffing schedules and posted hours were reviewed 10/1/19, through 11/12/19, and revealed the following:
-On 10/4/19, the schedule indicated there were two NAs on the 200 unit, SD verified the NA ratio would have been 1:15 to 16;
-On 10/10/19, the schedule indicated from 4:00 a.m. until 6:00 a.m. the 200 unit NA covered both 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 835	Continued From page 133	F 835		

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 DON was interviewed on 11/8/19, at 1:02 p.m. and stated staff had been cut back this year and she asked the administrator to increase nursing staff, however the DON indicated the administrator's response was no. The DON stated the administrator wanted to take a new admission with a trach on the transition care unit, however she told him absolutely not due to the complexity of the resident considering the acuity on the transition care unit was high already and staff would need to be increased.

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.

During interview with medical director (MD) on 11/12/19, at 4:32 p.m. MD stated he attended the QAPI meetings and was aware some residents stated there is a long wait time with call lights to

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

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F 835	Continued From page 134	F 835		

get staff response for assistance. MD stated discussion had been made regarding call light wait time and staffing. MD stated, "It was probably staffing not quite meeting the ratio and could be improved." MD stated he was not aware of any call light wait time audits being completed.

The administrator and DON were interviewed on 11/12/19, at 12:48 p.m. The administrator stated six to eight months ago the facility was staffed on the 200 unit with one TMA, three NAs and one nurse; on the 100 unit two NAs and one nurse and on the 300 unit two NA's and one nurse. The administrator indicated at that time the amount of staff in the building equaled 3.99 to 4.00 hours per patient per day (ppd). The administrator indicated during that time the staff were "saying they couldn't do it and it was not making sense." The administrator indicated the decision was made by himself and the DON to split the 300 unit nurse to also care for six residents on the 200 unit. The administrator indicated he did not feel as if the staff were "prioritizing" their time when complaining about not having had enough staff and indicated due to the lack of prioritization of staff "it's really tough for me to go to my superior to say" the facility was over budget for the last eight months. The administrator indicated in 2/2019, the facility made "adjustments" and decreased staff by one TMA on the 200 unit and one NA on the 300 unit. The administrator stated "we were aware the staff were complaining" and unhappy with the staffing decrease. The administrator explained in 9/2019, he received the directive from his "superiors" at corporate to decrease the staffing to a 3.2 ppd for direct care staff, however the administrator indicated he was able to get the Chief Executive Officer (CEO) to agree on 3.3 ppd. The administrator stated he

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

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F 835	Continued From page 135	F 835		

would receive calls from corporate questioning why we were over in staffing hours. The administrator indicated "we try to have a united front" the ppd was "out of our hands we are working with the corporate" office. The administrator indicated at one point he increased staff based on acuity, however indicated their current acuity of 0.9 did not reflect a need to increase staff. The administrator indicated he was able to go back to the CEO and ask for another NA with a census of 65, however confirmed he had not gone back to the CEO to ask for more staff based on staff and resident expressed concerns with long wait times. The DON stated part of the issue was "lack of system" to chart and capture acuity to support what the staff were doing for each resident. The DON indicated they continued to work with the staff, however the staff did not understand the accuracy of the charting which would then be reflected in case mix numbers and in turn would impact staffing hours. The administrator indicated with a census of 51, which was confirmed as the current census for that day, the NAs were staffed at a 1:12.75 and not 1:11 as indicated in the facility assessment. The administrator indicated department heads at the facility were expected to assist with answering call lights when needed. The administrator stated he was aware of complaints during resident council regarding long call lights and indicated he went onto the unit to see if the resident's needs were met and further indicated "some" of the resident's concerns were related to staff talking to residents about their own concerns. The administrator indicated regardless of the amount of staff residents were still waiting for their call lights to be answered. The administrator indicated he did not think it was a lack of staffing, however indicated he believed staff "don't want to work to

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 835	Continued From page 136 their ability."	F 835		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.	F 838		12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 838	Continued From page 137 §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility 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:	F 838	1.The facility assessment has been reviewed and updated on 12/17/2019. The facility assessment will be reviewed by our QA committee on 12/19/2019 to ensure accuracy 2.This has the potential to affect all residents in the facility 3.Department heads have been in serviced on the facility assessment on 12/17/2019 to ensure it accurately reflects the needs of our residents and who we provide care. 4.The administrator or designee will audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 838	Continued From page 138 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 (d/x) dated 11/12/19, which included: R9 had a d/x of alcohol dependence since admission; R25 had a d/x of alcohol use since admission; R14 had a d/x of alcoholic cirrhosis since admission; R18 had a d/x of alcohol abuse since admission; R12 had a d/x of alcohol dependence since admission; R43 had a d/x of opioid abuse since admission; R32 had a d/x of opioid dependence since admission; R27 had a d/x of alcohol abuse since admission; R54 had a d/x of alcohol dependence since admission. Nursing assistant (NA)-B was interviewed on 11/5/19, at 2:32 p.m. and stated they did not have enough staff to meet the resident's care needs. NA-B indicated there were too many resident who needed to be transferred with mechanical lifts which required two NAs and too many resident with behaviors who required attention and which resulted in cares that would not get done due to the high acuity on the 200 unit. NA-C was interviewed on 11/6/19, at 8:41 a.m. and stated there was not enough staff especially when there was a call in and there would only be two NAs for 30 plus residents on the 200 unit. NA-C indicated due to resident care needs the staff would do the best they could just to complete the essential cares for the day.	F 838	to ensure compliance with sufficient staffing. Audits will be completed weekly x 4 and then monthly x 2. Results will be reviewed by our Quality committee for further recommendations.	

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 838	Continued From page 139	F 838		

Licensed practical nurse (LPN)-C was interviewed on 11/6/19, at 2:21 p.m. and stated on average the staff would only have two NA's instead of three twice weekly. LPN-C stated there had been long call lights as a result of not enough staff and indicated some of the residents whom resided on the 200 unit required more patience and assistance which required more staff time and resulted in resident cares not having been completed.

The Facility Assessment reviewed 9/19/19, indicated the assessment was used to determine what resources were necessary to care for the residents competently during both day to day operations and emergencies. Staff were scheduled to ensure sufficient staff were able to meet the needs of the residents at any given time and further indicated staff patterns were adjusted based on census and acuity levels while providing appropriate support for the residents. The assessment indicated direct care staff- NA were to have had a 1:11 ratio on days/ evenings and 1:14 ratio during overnights in long term care. The assessment further indicated during the overnight there was to have been 1:50 ratio for nurses. Furthermore, the assessment identified assistance with activities of daily living in conjunction to the identified staffing ratios included transfer assistance for an independent resident range 1-26, one to two staff range of residents 1-20 and dependent resident range 1-20 and behavioral health needs resident range 1-20.

The staffing director (SD) was interviewed on 11/8/19, at 9:01 a.m. and stated the facility would staff one NA on the 100 unit, three NAs on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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

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F 838	Continued From page 140 200 unit and one NA on the 300 unit plus one nurse per unit on days/ evenings. SD stated on overnight shift there would be one NA per unit, one nurse for the 100 unit and one nurse for the 200 and 300 unit. During the interview SD verified the following staffing schedules and posted hours were reviewed from 10/1/19, through 11/12/19, and revealed the following: -On 10/4/19, the schedule indicated there were two NAs on the 200 unit, SD verified the NA ratio would have been 1:15 to 16; -On 10/10/19, the schedule indicated from 4:00 a.m. until 6:00 a.m. the 200 unit NA covered both 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 director of nursing (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	F 838		

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

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F 838	Continued From page 141 when there were call in's the staffing ratio would have been around 1:12.75 or greater. The administrator explained they also staff based on acuity and indicated their current acuity level was 0.9 which 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 facility assessment policy was requested, but not provided.	F 838		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the QAPI (Quality Assurance Performance Improvement) committee identified quality deficiencies with breaks in systems and incorporated action plans for improvement for resident care and services. (see F565 E, F677 E, F689 E, F725 F, F730 E, F755 E, F835 F, F838 F, F947 E) This had the potential to affect all 51 residents and their visitors in the facility. Findings include: During interview with administrator on 11/12/19, at 2:18 p.m. the Administrator stated the facility had needed to utilize agency staff and contract	F 867	1.It is facility policy to ensure we active Quality Assurance Performance Improvement committee to identify quality deficiencies with breaks in systems and incorporated action plans for improvement for resident care and services. 2.This has the potential to affect all residents in our facility 3.All staff have been in serviced on Quality Assurance Performance Improvement committee functions and facility policy of the Quality Assurance Performance Improvement committee program on 12/19/2019. 4.The administrator or designee will audit for compliance. Audits will be completed	12/29/19

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

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F 867	Continued From page 142 workers. The administrator stated they were presently trying to recruit new employees and had a QAPI action plan to get staff performance reviews up to date. Administrator stated he was not aware of any complaints of residents waiting long for call lights to be answered until yesterday when a resident and family member made him aware of a long call light wait for staff assistance. Administrator stated no call light audits had been completed to determine staff response time to residents' request for assistance. Administrator stated he had not read the resident council minutes concerns of long call lights and staffing and stated the department heads were responsible for follow up with the monthly concerns from resident council. Administrator stated the resident council concerns of long call light wait time and staffing had not been brought to QAPI and had not been discussed and QAPI had made no action plan for long call lights. Administrator stated satisfaction surveys with residents and families were no longer being completed since the beginning of the year when corporate had stopped the process. During interview with medical director (MD) on 11/12/19, at 4:32 p.m. MD stated he attended the QAPI meetings and was aware some residents stated there is a long wait time with call lights to get staff response for assistance. MD stated discussion had been made regarding call light wait time and staffing. MD stated, "It was probably staffing not quite meeting the ratio and could be improved." MD stated he was not aware of any call light wait time audits being completed. MD stated he had been made aware of the narcotics diversion in June and stated the issue had been addressed with the particular staff and the staff dismissed. MD stated he had not been	F 867	monthly for 6 months. Results will be reviewed by the governing board for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 143	F 867		

made aware of the September narcotics diversion and was not aware of any audits or monitoring being done.

During interview with the director of nursing (DON) on 11/12/19, at 12:22 p.m. DON verified R32's two bottles of morphine sulfate with 1.00 ml (milliliters) and 8.00 ml were "missing." DON explained licensed practical nurse (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 of morphine. DON verified R32 did not have any medication disposition records on file. DON stated she did not audit the narcotic reconciliation books and stated it was her expectation that all narcotics were reconciled at every shift change with two staff. DON stated she had no other monitoring being completed for medication storage/administration or monitoring or documentation on the units for narcotic diversion.

During interview with the administrator on 11/12/19, at 12:40 p.m. administrator confirmed there were no formal audits of narcotic use completed and/or documentation.

During interview with the consultant pharmacist (CP) via telephone on 11/12/19, at 2:57 p.m. CP 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 Meeting Agenda minutes indicated the percentage (%) of resident bathing with choice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 144	F 867		

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.

Review of the October 17, 2019, QAA/QAPI Meeting Agenda minutes indicated under "Measure" what % of staff did not have annual competency, training and performance review completed timely not identified. Action plan indicated nursing would get the staff performance reviews up to date but did not say by what date. The October QAPI minutes indicated bathing lists were not matching with NAs charting with Action "to get the lists updated" with no one noted who was responsible for follow up and by what date. Review of the October QAPI minutes did not reveal evidence of any discussion of resident call light waiting time for staff assistance or sufficient staffing. Furthermore, the October minutes did not reveal any evidence of discussion of narcotics diversion or monitoring of medication storage/administration.

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 long call light wait time for resident requests for staff assistance.

The facility QAPI (Quality Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 867	Continued From page 145 Performance Improvement) Plan dated Revision 6/5/18, indicated the QAPI plan provided guidance for overall Quality Improvement program and would drive decision making that promoted excellence in quality of care, of life, resident choice, person centered directed care, and resident transitions. The QAPI plan indicated focus areas would include all systems that affected resident and family satisfaction, quality of care and services provided, and all areas that affected the quality of life for persons living in the facility. The QAPI plan indicated Performance Improvement Projects (PIPS) were designed to take a systematic approach to revise and improve care or services in areas identified that needed attention. The QAPI plan indicated an important aspect of the PIPS is the plan determined the effectiveness of the PIPS and whether the improvement was sustained. The QAPI plan also indicated the QAPI plan would be reviewed annually by the QAPI committee. The QAPI plan did not indicate it was reviewed annually.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		12/29/19

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F 880	Continued From page 146 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 147 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide safe handling of catheter bag and tubing in accordance with infection control standards of practice for 1 of 1 resident (R20). In addition, the facility failed to ensure proper handwashing and glove usage for R20 during observation of care for a suprapubic catheter (a catheter placed below the navel into the bladder to drain urine). Findings Include: R20 was observed on 11/5/19, at 8:09 a.m. and his urinary catheter tubing was dragging on the floor. The urine drainage bag was uncovered and hooked under the wheelchair as resident propelled himself around the dining room area to the television area, back and forth. The emptying spout was out of the holder although it was clamped and observed dragging on the floor. R20 was observed again on 11/06/19, at 10:36 a.m. the drainage bag was covered with a privacy bag, however the bag and the tubing were dragging on the floor.	F 880	1.The facility□s policy to maintain an infection prevention program for all related to nursing cares provided to residents. Nursing staff competencies including catheter care and dressing changes are verified upon hire, annually and as needed by the Clinical Nurse Educator and/or designee. R20 has been provided a catheter bag holder to keep bag and tubing off the floor. 2.This has the potential to affect all facility resident with catheters 3.Nursing staff will be re-educated on infection control practices related to catheter care and the use of privacy bags by 12/29/2019. The education will include a review of infection control standards expected when providing resident care to minimize infections. 4.The infection preventionist or designee will audit for compliance. Audits will be completed daily x 4 weeks, weekly x 4, monthly x 1. Results will be reviewed by our Quality committee for further recommendation.	

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F 880	Continued From page 148	F 880		

Review of admission Minimum Data Set (MDS) assessment dated 8/14/19, indicated R20 had diagnoses that included Alzheimer's disease and dementia; had an indwelling catheter and required extensive assistance with toilet use, bed mobility and transfers.

R20's admission record dated 8/7/19 indicated R20 had diagnoses of retention of urine and history of malignant neoplasm of the prostate. Review of care plan dated 8/13/19, revealed R20 had suprapubic catheter. Physician order dated 9/3/19, indicated R20 had permanent suprapubic catheter, cleanse site with normal saline, pat dry, apply split gauze to secure two times a day for catheter cares.

Licensed Practical Nurse (LPN)-E was observed providing care and treatment for R20 on 11/7/19, at 9:41 a.m. LPN-E donned gloves and used ProCare wipes to clean R20's bottom after R20 had a small bowel movement. LPN-E removed gloves and sanitized hands with foam hand sanitizer. LPN-E then proceeded to change the dressing on the suprapubic catheter site. LPN-E took off the old dressing with noted drainage to the dressing. LPN-E without changing gloves or performing hand hygiene took ProCare wet wipes and cleansed the catheter site with the wipes. After cleaning site with the wet wipes LPN-E then applied a new gauze and taped it in place. After all cares were completed LPN-E washed his hands at the sink.

Nurse Manager, Registered Nurse (RN)-A was interviewed on 11/07/19, at 8:55 a.m. RN-A stated R20 was on hospice and orders were to complete suprapubic site care twice a day. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 149	F 880		

expectations was the catheter tubing should not be dragging on the floor and the urine drainage bag should be kept in a privacy bag. RN-A also verified the ProCare wet wipes were to be used for incontinent cares only.

LPN-E was interviewed on 11/8/19, at 10:17 a.m. LPN-E stated the current order for suprapubic site care was to clean with normal saline and apply gauze. LPN-E also verified that he did not use normal saline and instead used the ProCare wet wipes during suprapubic site care.

Assistant Director of Nursing, Registered Nurse (RN)-B, was interviewed on 11/08/19, at 12:04 p.m. RN-B verified she was also the Infection Control Nurse. RN-B stated it was the expectation staff changed gloves and washed hands after cleaning up after a bowel movement and before providing care for the suprapubic dressing change. RN-B explained Infection control education was usually done with facility staff, however, agency pool staff were assumed to have infection control competencies prior to providing care in the facility. RN-B further stated the facility did not have a system for training pool staff on infection control.

Review of undated facility policy entitled Infection Control Guidelines for all Nursing Procedures, indicates Standard Precautions will be used in the care of all residents. Standard precautions apply to blood, body fluids, secretions and excretions. Employees must wash hands for 10 to 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after contact with blood, body fluids, secretions, mucous membranes or non-intact skin; after handling items potentially

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 150 contaminated with blood, body fluids or secretions; after removing gloves.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This 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 51 residents who resided in the facility. Findings include: Review of E4's personnel file revealed a hire date of 8/7/19. E4's personnel file revealed E4 was a NA. E4's file revealed no evidence of	F 947	1.It is the facility policy to ensure that all staff have been trained abuse/ vulnerable adult, dementia training and infection control at time of hire. 2.This has the potential to affect all facility residents 3.All staff files have been reviewed to ensure compliance with training for abuse/vulnerable adult, dementia training and infection control. All staff including contract employees will be in serviced on	12/29/19

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	245304	A. BUILDING _____ B. WING _____	C 11/12/2019

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F 947	Continued From page 151 abuse/vulnerable adult (VA) and Alzheimer's (AZ)/Dementia training completed. E4's file revealed no evidence of Infection Control (IC) training. Review of E5's personnel file revealed a hire date of 7/21/19. E5's personnel file revealed E5 was a NA. E5's file revealed no evidence of abuse/VA and AZ/Dementia training completed. E5's file revealed no evidence of IC training. Review of E6's personnel file revealed a hire date of 11/29/18. E6's personnel file revealed E6 was a NA. E6's file revealed no evidence of abuse/VA and AZ/Dementia training completed. E6's file revealed no evidence of IC training. Review of E7's personnel file revealed a hire date of 10/4/19. E7's personnel file revealed E7 was a licensed practical nurse. E7's file revealed no evidence of abuse/VA and AZ/Dementia training completed. E7's file revealed no evidence of IC training. During interview with Human Resources (HR)/Staffing Director (SD) on 11/12/19, at 10:39 a.m. HR/SD confirmed there was no Abuse/VA, AZ/Dementia, and IC training in E4's, E5's, E6's, and E7's personnel files. HR/SD stated the facility had hired E4, E5, E6, and E7 as contract workers and were employed by the facility. HR/SD stated training had not been provided to the contract workers. A policy was requested from the facility and not provided.	F 947	abuse/vulnerable adult, dementia training and infection control by 12/29/2019. 4.Human resources or designee will be responsible to ensure compliance. Audits will be completed monthly x 3. Results will be reviewed by our Quality committee for further recommendation.	

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (The Gardens at Cannon Falls) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: fm.hc.Inspections@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/29/2019

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.

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

This facility will be surveyed as one building. The Gardens at Cannon Falls Former (Angels Care Center) is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1977 and was determined to be of Type II(111) construction. In 1982, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1985, another addition was added to the South Wing and was determined to be Type II (111). In 2007 the chapel was added and was determined to be Type V (111) with a 2 hour separation.

The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 74 beds and had a census of 52 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly secure these stoves when unattended by staff in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.3.2.5.3). This deficient practice could affect 52 residents. Findings Include: On facility tour between 08:00 AM and 01:00 PM	K 324	1. We contacted our electrician to install a timer/switch that would automatically shutoff the stove after a certain time limit. 2. this will be completed when the equipment arrives. 3. The environmental service director will be responsible for correction and monitoring to prevent reoccurrence	12/29/19

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2019**

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K 324	Continued From page 3 on 11/07/2019, observations and staff interview revealed the following: During walk-through of the facility observed - Wing 100 Activities Room and the Chapel each has stoves that did not have a switch that could deactivate the units when not under staff supervision. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 324		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to conduct	K 353	1.We contacted our sprinkler system monitoring company to come out and	12/29/19

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 4 quarterly testing of the sprinkler system in accordance with the Life Safety Code NFPA 101 - 2012 edition (9.7.5, 9.7.7, 9.7.8, and NFPA 25). This deficient practice could affect 52 residents. Findings Include: On facility tour between 08:00 AM and 01:00 PM on 11/07/2019, documentation review and staff interview revealed the following: During documentation review - no records were provided to confirm that quarterly sprinkler system testing was completed for Q2 - 2019 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	inspect our sprinkler system 2. This was completed on 11/22/2019 3. The environmental service director will be responsible for correction and monitoring to prevent reoccurrence.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the Life Safety Code NFPA 101 - 2012 edition (19.7.1.4 through 19.7.1.7). This	K 712	1.The environmental service director was re-educated on 11/12/2019 2. Fire drill was completed on 11/30/2019 3. The environmental service director will	12/29/19

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/04/2019**

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

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K 712	Continued From page 5 deficient practice could affect 52 residents. Findings Include: On facility tour between 08:00 AM and 01:00 PM on 11/07/2019, observation and documentation reviewed revealed the following: During documentation review - no records were provided to confirm that fire drills were conducted: Q1 2019 (3rd shift); Q2 2019 (2nd shift); Q4 2018 (2nd shift) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	be responsible for correction and monitoring to prevent reoccurrence.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain a medical gas (O2) training program in accordance with the Life Safety Code NFPA 101 - 2012 edition (11.5.2.1 (NFPA 99)). This deficient practice could affect 52 residents. Findings Include:	K 926	1.Oxygen training for all nursing staff will be completed by/on 12/29/2019 2. The DNS or designee will monitor for compliance to prevent reoccurrence	12/29/19

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K 926	Continued From page 6 On facility tour between 08:00 AM and 01:00 PM on 11/07/2019, observation and documentation reviewed revealed the following: During documentation review - no records provided to confirm that initial -or- on-going med gas training is being provided to and completed by care staff. (previously sited under Project # F5304029) This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 926		

DEPARTMENT OF HEALTH

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 only a suggestion 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

"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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 11/4/19 through 11/12/19, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, the following complaints were found to be substantiated: H5304060C order issued at St 0830 H5304061C order issued at St 0830 H5304062C order issued at St 0830 H5304063C order issued at St 0830 H5304064C order issued at St 1525 H5304065C order issued at St 0830 H5304066C order issued at St 0830 H5304067C order issued at St 0830 H5304069C order issued at St 1995, and St 2000 H5304070C order issued at St 0830 Additionally, complaint H5304068C was found to be unsubstantiated	2 000		
2 130	MN Rule 4658.0050 Subp. 1 Licensee;General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management,	2 130		12/29/19

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2 130	Continued From page 2 control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 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. Findings include: On 11/6/19, at 1:28 p.m. members of the resident council group met to review the facility resident council function. The following residents attended and provided the following information: -R24 stated "nothing gets fixed" here we have had to wait a long time for call lights to get answered, however nobody did anything to follow-up with our concern; -R12 stated residents had to wait a long time for call lights to be answered; -R18 stated she had to wait a long time for staff assistance and indicated if you were in your room during meal times you would have to wait even "longer" for the call light to be answered. R18 stated staffing had gotten worse over the past couple of months; -R37 stated wait time for staff assistance had	2 130	Corrected	

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2 130	Continued From page 3	2 130		

increased during the past few months and at times he would not get showers due to not enough staff;
-R15 stated there were long wait times for call light response and indicated due to this staff were not always able to accommodate his choice regarding getting up at 4:30 a.m.

Resident council meeting minutes and response letters were reviewed from 4/24/19, through 10/30/19, and revealed the following:
-The minutes dated 4/29/19, indicated a concern regarding call lights were not answered timely and residents felt ignored as staff were turning off their call light without responding to their request;
-A letter dated 5/7/19, in response to the resident council lacked evidence of call light and staff concerns;
-The minutes dated 5/29/19, indicated a concern regarding call lights not answered during meal times and call lights were still being turned off without providing the requested assistance;
-The minutes dated 6/26/19, indicated call lights not being answered timely, residents reported on average 45 minutes to one hour wait time. The minutes indicated call lights were still being turned off without assisting the resident. The minutes further indicated they were being told there was not enough staff and showers and/ or baths were not being completed;
-The minutes dated 7/31/19, indicated residents were frustrated regarding no resolution and feeling as nothing was being done regarding the long call lights;
-The minutes dated 10/10/19, indicated 20 residents and five staff were in attendance and still no follow up on long call light wait times;
-The minutes dated 10/30/19, indicated concerns expressed regarding not enough staff during the overnight shift and still waiting for a response

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2 130	Continued From page 4 regarding long call lights wait times. The resident council meeting minutes and response letters lacked evidence of follow-up related to continued concerns of long call light wait times. The ombudsman (OMB) was interviewed on 11/6/19, at 1:37 p.m. and stated there was repeated staffing issues. The OMB stated residents complained there was not enough staff to meet their care needs and indicated the OMB reached out to the director of nursing (DON) a week ago regarding these concerns, however had not received a response. The administrator was interviewed on 11/12/19, at 2:18 p.m. and verified each department head was responsible to follow up on each identified concern from resident council. During the survey 11/4/19, through 11/12/19, the following areas of concern were identified: See F561: 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. See F677: 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). See F725: Based on observation, interview and document review, the facility failed to ensure sufficient staff were available to meet resident needs for 4 of 5 residents (R44, R43, R46, R7)	2 130		

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2 130	Continued From page 5	2 130		

dependent on staff for activities of daily (ADLs) and for 5 of 9 residents (R24, R12, R18, R37, R51) whom expressed concerns during resident council meeting. In addition, the facility failed to provide supervision to reduce resident to resident altercations for 5 of 5 residents (R15, R33, R55, R56, R57) in the memory unit.

The Facility Assessment reviewed 9/19/19, indicated the assessment was used to determine what resources were necessary to care for the residents competently during both day to day operations and emergencies. Staff were scheduled to ensure sufficient staff were able to meet the needs of the residents at any given time and further indicated staff patterns were adjusted based on census and acuity levels while providing appropriate support for the residents. The assessment indicated direct care staff- NA were to have had a 1:11 ratio on days/ evenings and 1:14 ratio during overnights in long term care. The assessment further indicated during the overnight there was to have been 1:50 ratio for nurses. Furthermore, the assessment identified assistance with activities of daily living in conjunction to the identified staffing ratios included transfer assistance for an independent resident range 1-26, one to two staff range of residents 1-20 and dependent resident range 1-20 and behavioral health needs resident range 1-20.

The staffing director (SD) was interviewed on 11/8/19, at 9:01 a.m. and stated the facility would staff one NA on the 100 unit, three NAs on the 200 unit and one NA on the 300 unit plus one nurse per unit on days/ evenings. SD stated on overnight shift there would be one NA per unit, one nurse for the 100 unit and one nurse for the 200 and 300 unit. During the interview SD verified

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2 130	Continued From page 6 the following staffing schedules and posted hours were reviewed 10/1/19, through 11/12/19, and revealed the following: -On 10/4/19, the schedule indicated there were two NAs on the 200 unit, SD verified the NA ratio would have been 1:15 to 16; -On 10/10/19, the schedule indicated from 4:00 a.m. until 6:00 a.m. the 200 unit NA covered both 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 DON was interviewed on 11/8/19, at 1:02 p.m. and stated staff had been cut back this year and she asked the administrator to increase nursing staff, however the DON indicated the administrator's response was no. The DON stated the administrator wanted to take a new admission with a trach on the transition care unit, however she told him absolutely not due to the complexity of the resident considering the acuity on the transition care unit was high already and staff would need to be increased.	2 130		

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2 130	Continued From page 7 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. During interview with medical director (MD) on 11/12/19, at 4:32 p.m. MD stated he attended the QAPI meetings and was aware some residents stated there is a long wait time with call lights to get staff response for assistance. MD stated discussion had been made regarding call light wait time and staffing. MD stated, "It was probably staffing not quite meeting the ratio and could be improved." MD stated he was not aware of any call light wait time audits being completed. The administrator and DON were interviewed on 11/12/19, at 12:48 p.m. The administrator stated six to eight months ago the facility was staffed on the 200 unit with one TMA, three NAs and one nurse; on the 100 unit two NAs and one nurse and on the 300 unit two NA's and one nurse. The administrator indicated at that time the amount of staff in the building equaled 3.99 to 4.00 hours per patient per day (ppd). The administrator indicated during that time the staff were "saying they couldn't do it and it was not making sense." The administrator indicated the decision was made by himself and the DON to split the 300 unit	2 130		

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2 130	Continued From page 8	2 130		

nurse to also care for six residents on the 200 unit. The administrator indicated he did not feel as if the staff were "prioritizing" their time when complaining about not having had enough staff and indicated due to the lack of prioritization of staff "it's really tough for me to go to my superior to say" the facility was over budget for the last eight months. The administrator indicated in 2/2019, the facility made "adjustments" and decreased staff by one TMA on the 200 unit and one NA on the 300 unit. The administrator stated "we were aware the staff were complaining" and unhappy with the staffing decrease. The administrator explained in 9/2019, he received the directive from his "superiors" at corporate to decrease the staffing to a 3.2 ppd for direct care staff, however the administrator indicated he was able to get the Chief Executive Officer (CEO) to agree on 3.3 ppd. The administrator stated he would receive calls from corporate questioning why we were over in staffing hours. The administrator indicated "we try to have a united front" the ppd was "out of our hands we are working with the corporate" office. The administrator indicated at one point he increased staff based on acuity, however indicated their current acuity of 0.9 did not reflect a need to increase staff. The administrator indicated he was able to go back to the CEO and ask for another NA with a census of 65, however confirmed he had not gone back to the CEO to ask for more staff based on staff and resident expressed concerns with long wait times. The DON stated part of the issue was "lack of system" to chart and capture acuity to support what the staff were doing for each resident. The DON indicated they continued to work with the staff, however the staff 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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	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 130	Continued From page 9 The administrator indicated with a census of 51, which was confirmed as the current census for that day, the NAs were staffed at a 1:12.75 and not 1:11 as indicated in the facility assessment. The administrator indicated department heads at the facility were expected to assist with answering call lights when needed. The administrator stated he was aware of complaints during resident council regarding long call lights and indicated he went onto the unit to see if the resident's needs were met and further indicated "some" of the resident's concerns were related to staff talking to residents about their own concerns. The administrator indicated regardless of the amount of staff residents were still waiting for their call lights to be answered. The administrator indicated he did not think it was a lack of staffing, however indicated he believed staff "don't want to work to their ability." SUGGESTED METHOD FOR CORRECTION: The administrator,director of nursing or designee could develop and implement policies and procedures to ensure adequate resources were available to maintain the highest practicable physical, mental and psychosocial well-being of each resident. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 130		
2 240	MN Rule 4658.0065 Subp. 3 Resident Safety and Disaster Planning Subp. 3. Written disaster plan. A nursing home must have a written disaster plan specific to the nursing home with procedures for the protection	2 240		12/29/19

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2 240	Continued From page 10 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 or 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 (d/x) dated 11/12/19, which included:	2 240	Corrected	

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2 240	Continued From page 11 R9 had a d/x of alcohol dependence since admission; R25 had a d/x of alcohol use since admission; R14 had a d/x of alcoholic cirrhosis since admission; R18 had a d/x of alcohol abuse since admission; R12 had a d/x of alcohol dependence since admission; R43 had a d/x of opioid abuse since admission; R32 had a d/x of opioid dependence since admission; R27 had a d/x of alcohol abuse since admission; R54 had a d/x of alcohol dependence since admission. Nursing assistant (NA)-B was interviewed on 11/5/19, at 2:32 p.m. and stated they did not have enough staff to meet the resident's care needs. NA-B indicated there were too many resident who needed to be transferred with mechanical lifts which required two NAs and too many resident with behaviors who required attention and which resulted in cares that would not get done due to the high acuity on the 200 unit. NA-C was interviewed on 11/6/19, at 8:41 a.m. and stated there was not enough staff especially when there was a call in and there would only be two NAs for 30 plus residents on the 200 unit. NA-C indicated due to resident care needs the staff would do the best they could just to complete the essential cares for the day. Licensed practical nurse (LPN)-C was interviewed on 11/6/19, at 2:21 p.m. and stated on average the staff would only have two NA's instead of three twice weekly. LPN-C stated there had been long call lights as a result of not enough staff and indicated some of the residents whom resided on the 200 unit required more patience	2 240		

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2 240	Continued From page 12	2 240		

and assistance which required more staff time and resulted in resident cares not having been completed.

The Facility Assessment reviewed 9/19/19, indicated the assessment was used to determine what resources were necessary to care for the residents competently during both day to day operations and emergencies. Staff were scheduled to ensure sufficient staff were able to meet the needs of the residents at any given time and further indicated staff patterns were adjusted based on census and acuity levels while providing appropriate support for the residents. The assessment indicated direct care staff- NA were to have had a 1:11 ratio on days/ evenings and 1:14 ratio during overnights in long term care. The assessment further indicated during the overnight there was to have been 1:50 ratio for nurses. Furthermore, the assessment identified assistance with activities of daily living in conjunction to the identified staffing ratios included transfer assistance for an independent resident range 1-26, one to two staff range of residents 1-20 and dependent resident range 1-20 and behavioral health needs resident range 1-20.

The staffing director (SD) was interviewed on 11/8/19, at 9:01 a.m. and stated the facility would staff one NA on the 100 unit, three NAs on the 200 unit and one NA on the 300 unit plus one nurse per unit on days/ evenings. SD stated on overnight shift there would be one NA per unit, one nurse for the 100 unit and one nurse for the 200 and 300 unit. During the interview SD verified the following staffing schedules and posted hours were reviewed from 10/1/19, through 11/12/19, and revealed the following:
-On 10/4/19, the schedule indicated there were

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2 240	Continued From page 13	2 240		

two NAs on the 200 unit, SD verified the NA ratio would have been 1:15 to 16;
-On 10/10/19, the schedule indicated from 4:00 a.m. until 6:00 a.m. the 200 unit NA covered both 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 director of nursing (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 staff based on acuity and indicated their current acuity level was 0.9 which 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 facility assessment policy was requested, but

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2 240	Continued From page 14 not provided. SUGGESTED METHOD OF CORRECTION: The administrator could review/revise policies/procedures for the facility assessment components, educate staff and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 240		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the QAPI (Quality Assurance Performance Improvement) committee identified quality deficiencies with breaks in systems and incorporated action plans for improvement for resident care and services.	2 255	Corrected	12/29/19

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2 255	Continued From page 15 (see F565 E, F677 E, F689 E, F725 F, F730 E, F755 E, F835 F, F838 F, F947 E) This had the potential to affect all 51 residents and their visitors in the facility. Findings include: During interview with administrator on 11/12/19, at 2:18 p.m. the Administrator stated the facility had needed to utilize agency staff and contract workers. The administrator stated they were presently trying to recruit new employees and had a QAPI action plan to get staff performance reviews up to date. Administrator stated he was not aware of any complaints of residents waiting long for call lights to be answered until yesterday when a resident and family member made him aware of a long call light wait for staff assistance. Administrator stated no call light audits had been completed to determine staff response time to residents' request for assistance. Administrator stated he had not read the resident council minutes concerns of long call lights and staffing and stated the department heads were responsible for follow up with the monthly concerns from resident council. Administrator stated the resident council concerns of long call light wait time and staffing had not been brought to QAPI and had not been discussed and QAPI had made no action plan for long call lights. Administrator stated satisfaction surveys with residents and families were no longer being completed since the beginning of the year when corporate had stopped the process. During interview with medical director (MD) on 11/12/19, at 4:32 p.m. MD stated he attended the QAPI meetings and was aware some residents stated there is a long wait time with call lights to get staff response for assistance. MD stated	2 255		

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2 255	Continued From page 16	2 255		

discussion had been made regarding call light wait time and staffing. MD stated, "It was probably staffing not quite meeting the ratio and could be improved." MD stated he was not aware of any call light wait time audits being completed. MD stated he had been made aware of the narcotics diversion in June and stated the issue had been addressed with the particular staff and the staff dismissed. MD stated he had not been made aware of the September narcotics diversion and was not aware of any audits or monitoring being done.

During interview with the director of nursing (DON) on 11/12/19, at 12:22 p.m. DON verified R32's two bottles of morphine sulfate with 1.00 ml (milliliters) and 8.00 ml were "missing." DON explained licensed practical nurse (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 of morphine. DON verified R32 did not have any medication disposition records on file. DON stated she did not audit the narcotic reconciliation books and stated it was her expectation that all narcotics were reconciled at every shift change with two staff. DON stated she had no other monitoring being completed for medication storage/administration or monitoring or documentation on the units for narcotic diversion.

During interview with the administrator on 11/12/19, at 12:40 p.m. administrator confirmed there were no formal audits of narcotic use completed and/or documentation.

During interview with the consultant pharmacist (CP) via telephone on 11/12/19, at 2:57 p.m. CP

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2 255	Continued From page 17 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 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. Review of the October 17, 2019, QAA/QAPI Meeting Agenda minutes indicated under "Measure" what % of staff did not have annual competency, training and performance review completed timely not identified. Action plan indicated nursing would get the staff performance reviews up to date but did not say by what date. The October QAPI minutes indicated bathing lists were not matching with NAs charting with Action "to get the lists updated" with no one noted who was responsible for follow up and by what date. Review of the October QAPI minutes did not reveal evidence of any discussion of resident call light waiting time for staff assistance or sufficient staffing. Furthermore, the October minutes did not reveal any evidence of discussion of narcotics diversion or monitoring of medication storage/administration.	2 255		

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2 255	Continued From page 18 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 long call light wait time for resident requests for staff assistance. The facility QAPI (Quality Assurance Performance Improvement) Plan dated Revision 6/5/18, indicated the QAPI plan provided guidance for overall Quality Improvement program and would drive decision making that promoted excellence in quality of care, of life, resident choice, person centered directed care, and resident transitions. The QAPI plan indicated focus areas would include all systems that affected resident and family satisfaction, quality of care and services provided, and all areas that affected the quality of life for persons living in the facility. The QAPI plan indicated Performance Improvement Projects (PIPS) were designed to take a systematic approach to revise and improve care or services in areas identified that needed attention. The QAPI plan indicated an important aspect of the PIPS is the plan determined the effectiveness of the PIPS and whether the improvement was sustained. The QAPI plan also indicated the QAPI plan would be reviewed annually by the QAPI committee. The QAPI plan did not indicate it was reviewed annually. SUGGESTED METHOD OF CORRECTION: The administrator could work with the DON or designee, medical director, and governing body to update polices and procedures, identify issues, develop improvement plans, and ensure the committee meets quarterly. The administrator and DON could audit cares to ensure resident needs are met, audit charts for completion of restorative and range of motion programs, and report results to the quality committee.	2 255		

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2 255	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. 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. Findings include: Review of E4's personnel file revealed a hire date of 8/7/19. E4's personnel file revealed E4 was a NA. E4's file revealed no evidence of abuse/vulnerable adult (VA) and Alzheimer's (AZ)/Dementia training completed. E4's file revealed no evidence of Infection Control (IC)	2 285	Corrected	12/29/19

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2 285	Continued From page 20 training. Review of E5's personnel file revealed a hire date of 7/21/19. E5's personnel file revealed E5 was a NA. E5's file revealed no evidence of abuse/VA and AZ/Dementia training completed. E5's file revealed no evidence of IC training. Review of E6's personnel file revealed a hire date of 11/29/18. E6's personnel file revealed E6 was a NA. E6's file revealed no evidence of abuse/VA and AZ/Dementia training completed. E6's file revealed no evidence of IC training. Review of E7's personnel file revealed a hire date of 10/4/19. E7's personnel file revealed E7 was a licensed practical nurse. E7's file revealed no evidence of abuse/VA and AZ/Dementia training completed. E7's file revealed no evidence of IC training. During interview with Human Resources (HR)/Staffing Director (SD) on 11/12/19, at 10:39 a.m. HR/SD confirmed there was no Abuse/VA, AZ/Dementia, and IC training in E4's, E5's, E6's, and E7's personnel files. HR/SD stated the facility had hired E4, E5, E6, and E7 as contract workers and were employed by the facility. HR/SD stated training had not been provided to the contract workers. A policy was requested from the facility and not provided. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures regarding ongoing education hours. The DON or designee could educate all staff. The	2 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 285	Continued From page 21 DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 335	MN Rule 4658.0130 Employees' Personnel Records 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. Employee health information, including the record of all accidents and those illnesses reportable under part 4605.7040, must be maintained and stored in a separate employee medical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 335	Corrected	12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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

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2 335	Continued From page 22 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 of 5/19/17. E3's personnel file revealed E3 was a NA who had worked at the facility over a year. E3's file revealed no 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. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policy for performance reviews, educate staff on those policies to ensure nursing staff, including nursing assistance, to staffs' performance has been reviewed. The DON or designee could conduct audits of employee files	2 335		

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2 335	Continued From page 23 to ensure the employee performance reviews have been completed on a consistent basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 335		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staff were available to meet resident needs for 4 of 5 residents (R44, R43, R46, R7) dependent on staff for activities of daily (ADLs) and for 5 of 9 residents (R24, R12, R18, R37, R51) whom expressed concerns during resident council meeting. In addition, the facility failed to provide supervision to reduce resident to resident altercations for 5 of 5 residents (R15, R33, R55, R56, R57) in the memory unit. The lack of sufficient nursing staffing had the potential to affect all 51 residents in the facility. Findings include: R44 was observed on 11/8/19, at 7:40 a.m. with	2 800	Corrected	12/29/19

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2 800	Continued From page 24	2 800		

his call light on. At 7:59 a.m. R44 indicated he had been on the bed pan waiting for "30 to 45 minutes" and needed assistance to get off of the bed pan as he had "been done for a long time." At 8:05 a.m. nursing assistant (NA)-A was observed to answer R44's call light when entering R44's room R44 stated to NA-A he had been "waiting more than I should." R44 was observed to have had a bowel movement NA-A provided pericares and assisted R44 off of the bed pan. R44 stated to NA-A he had been waiting "45 minutes" and NA-A replied "we are working as fast as the two of us can."

R44's quarterly Minimum Data Set (MDS) dated 10/7/19, identified R44 had intact cognition and diagnoses which included dementia and manic depression. The MDS indicated R44 required extensive assist with toileting and was frequent incontinent of bowel without a toileting program.

R44 was interviewed on 11/8/19, at 8:15 a.m. and stated staff when staff would call in he would wait a long time for assistance from staff after alerting his call light. R44 stated facility staff issues would occur almost daily and was worse on the weekends.

NA-A was interviewed on 11/8/19, at 8:20 a.m. and confirmed R44 was waiting at least 30 minutes on the bedpan. NA-A stated they were "really far behind" getting residents up for the day due to only having two NAs when they should have had three NAs.

NA-J was interviewed on 11/8/19, at 8:25 a.m. and verified there were only two NA's and should have had three NAs. NA-J stated they were behind due to having been "down a staff" and indicated there were still five resident's left to get

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2 800	Continued From page 25 up out of bed. The Staffing Director (SD) was interviewed on 11/8/19, at 9:01 a.m. and confirmed there were only two NA's working on the 200 unit instead of the needed three NAs. SD explained she was unable to find a nurse to work so the facility had to "pull" a NA to work as the trained medication aide which left only two NAs. The director of nursing (DON) was interviewed on 11/8/19, at 1:06 p.m. and stated she expected staff to respond as promptly as they were able. 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 report indicated bathing "Not Applicable;" -On 9/29/19, the report indicated bathing "Not Applicable;" -On 10/13/19, the report indicated bathing "Not Applicable;" -On 10/27/19, the report indicated independent with bathing; -On 10/31/19, the report indicated bathing "Not Applicable;" -On 11/7/19, after survey began, the report indicated extensive assist with bathing.	2 800		

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2 800	Continued From page 26 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 was interviewed on 11/6/19, at 8:32 a.m. and stated he "wants a shower." R43 was observed to have long 0.25 inch finger nails with brown dirt underneath the nail, dirty clothing with food stains on them, and R43 was malodorous. R43 stated he had not had a shower in over two weeks and when he had requested no staff would come back to assist him. NA-B was interviewed on 11/5/19, at 2:32 p.m. and verified R43 had not had a shower for three weeks. NA-B stated there were too many resident's whom required two people to provide cares and/ or transfers which would result in not enough staff to complete showers. NA-B explained in addition to residents whom required two staff there were also too many lifts which required two staff and resident's whom required constant behavior interventions for the staff to meet the resident's basic care needs. NA-B stated the staff had complained to the DON,	2 800		

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2 800	Continued From page 27 however indicated nothing changed. NA-C was interviewed on 11/6/19, at 8:41 a.m. and confirmed R43 had not had a shower in a while. NA-C explained "all the time the residents miss" their scheduled shower and the shower would be moved to the next day and/ or the next day due to not enough staff. NA-C indicated there was not time to look at updated resident care plans due to having been too busy. NA-C stated most days there were only two NAs for 30-32 residents and the staff did the best they could do just to complete incontinence care and/ or meet basic care needs of the residents. NA-C stated basic care was priority over showers. NA-C stated the staff had notified the DON they did not have enough staff to meet the resident care needs, however indicated no changes occurred. Licensed practical nurse (LPN)-C was interviewed on 11/6/19, at 2:21 p.m. and stated on average the staff would work on the 200 unit with two NAs vs. three NAs and indicated showers would not get done as it was not realistic for two NAs to complete all of the basic cares on the unit. LPN-C confirmed residents would wait a long time for their call lights to be answered and indicated "we don't always have the DON and nurse manager answering lights" they did that due to state having been here. DON was interviewed on 11/8/19, at 12:07 p.m. and stated it was her expectation for R43 to be showered per the shower schedule which was weekly. DON stated she expected a male staff to shower R43 per request and confirmed R43 had not been showered in the past two weeks. A subsequent DON interview was completed on 11/12/19, at 9:14 a.m. and stated the facility increased staffing on the weekend and was now	2 800		

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2 800	Continued From page 28 all caught up showers. NA-J was interviewed on 11/12/19, at 9:25 a.m. and stated there were not enough NAs and toileting and bathing/ showers would not get done. NA-J indicated three NAs were not enough due to acuity and care needs. NA-J stated the 200 unit needed four NAs to complete resident care timely. The facility policy regarding toileting was requested, but not provided. Resident Council On 11/6/19, at 1:28 p.m. members of the resident council group met to review the facility resident council function. The following residents attended and provided the following information: -R24 stated "nothing gets fixed" here we have had to wait a long time for call lights to get answered, however nobody did anything to follow-up with our concern; -R12 stated residents had to wait a long time for call lights to be answered; -R18 stated she had to wait a long time for staff assistance and indicated if you were in your room during meal times you would have to wait even "longer" for the call light to be answered. R18 stated staffing had gotten worse over the past couple of months; -R37 stated wait time for staff assistance had increased during the past few months and at times he would not get showers due to not enough staff; -R51 stated there were long wait times for call light response and indicated due to this staff were not always able to accommodate his choice regarding getting up at 4:30 a.m. Resident council meeting minutes and response letters were reviewed 4/24/19, through 10/30/19,	2 800		

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2 800	Continued From page 29 and revealed the following: -The minutes dated 4/29/19, indicated a concern regarding call lights were not answered timely and residents felt ignored as staff were turning off their call light without responding to their request; -A letter dated 5/7/19, in response to the resident council lacked evidence of call light and staff concerns; -The minutes dated 5/29/19, indicated a concern regarding call lights not answered during meal times and call lights were still being turned off without providing the requested assistance; -The minutes dated 6/26/19, indicated call lights not being answered timely, residents reported on average 45 minutes to one hour wait time. The minutes indicated call lights were still being turned off without assisting the resident. The minutes further indicated they were being told there was not enough staff and showers and/ or baths were not being completed; -The minutes dated 7/31/19, indicated residents were frustrated regarding no resolution and feeling as nothing was being done regarding the long call lights; -The minutes dated 10/10/19, indicated 20 residents and five staff were in attendance and still no follow up on long call light wait times; -The minutes dated 10/30/19, indicated concerns expressed regarding not enough staff during the overnight shift and still waiting for a response regarding long call lights wait times. The ombudsman (OMB) was interviewed on 11/6/19, at 1:37 p.m. and stated there was repeated staffing issues. OMB stated residents complained there was not enough staff to meet their care needs and indicated the OMB reached out to DON a week ago regarding these concerns, however had not received a response.	2 800		

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2 800	Continued From page 30 The Facility Assessment reviewed 9/19/19, indicated the assessment was used to determine what resources were necessary to care for the residents competently during both day to day operations and emergencies. Staff were scheduled to ensure sufficient staff were able to meet the needs of the residents at any given time and further indicated staff patterns were adjusted based on census and acuity levels while providing appropriate support for the residents. The assessment indicated direct care staff- NA were to have had a 1:11 ratio on days/ evenings and 1:14 ratio during overnights in long term care. The assessment further indicated during the overnight there was to have been 1:50 ratio for nurses. Furthermore, the assessment identified assistance with activities of daily living in conjunction to the identified staffing ratios included transfer assistance for an independent resident range 1-26, one to two staff range of residents 1-20 and dependent resident range 1-20 and behavioral health needs resident range 1-20. The staffing director (SD) was interviewed on 11/8/19, at 9:01 a.m. and stated the facility would staff one NA on the 100 unit, three NAs on the 200 unit and one NA on the 300 unit plus one nurse per unit on days/ evenings. SD stated on overnight shift there would be one NA per unit, one nurse for the 100 unit and one nurse for the 200 and 300 unit. During the interview SD verified the following staffing schedules and posted hours were reviewed 10/1/19, through 11/12/19, and revealed the following: -On 10/4/19, the schedule indicated there were two NAs on the 200 unit, SD verified the NA ratio would have been 1:15 to 16; -On 10/10/19, the schedule indicated from 4:00 a.m. until 6:00 a.m. the 200 unit NA covered both	2 800		

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2 800	Continued From page 31 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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2 800	Continued From page 32 assist due to behaviors and when the stand lift was used, however did not verify the actual number of residents. During interview with medical director (MD) on 11/12/19, at 4:32 p.m. MD stated he attended the QAPI meetings and was aware some residents stated there is a long wait time with call lights to get staff response for assistance. MD stated discussion had been made regarding call light wait time and staffing. MD stated, "It was probably staffing not quite meeting the ratio and could be improved." MD stated he was not aware of any call light wait time audits being completed. Call light audits were requested, but not provided. Sufficient staffing policy request, but not provided. 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)	2 800		

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2 800	Continued From page 33 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 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 6:29 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!"	2 800		

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 34 -At 6:30 p.m. DON entered unidentified room number which had call light on above door and exited room with call light still activated. -At 6:31 p.m. R46 observed sitting in his w/c in his room waiting for assistance to bed with call light on. -At 6:33 p.m. no call lights activated in hall 200 -At 6:33 p.m. R46 observed still waiting in his room to go to bed. -At 6:38 p.m. R10 and R54's call lights came on over their room doors. -At 6:40 p.m. R46 wheeled himself out of his room into hallway looking down hallway. RN-A told R46 she could get R46 hooked up to the lift while he was waiting. -At 6:44 p.m. R46 was observed sitting in his w/c in his room with RN-A present hooked up to the transfer lift. -At 6:47 p.m. NA walked into R46's room to assist RN-A to transfer R46 to bed. (R46 waited 41 minutes for staff assistance). -At 7:18 p.m. R46 stated to surveyor he wants to go to bed at 6:00 p.m. every evening. R46 stated he "waits that long all the time to go to bed, it's the usual." 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 bed. NA-B stated residents who needed less care at the last step of the process to bed went to bed first and the residents who required more steps last. NA-B stated there was not enough staff to wash residents up. NA-B stated that was generally the norm here at the facility. LPN-C stated on 11/6/19, at 2:21 p.m. showers could not be completed when only having two NAs. LPN-C stated last Sunday only had two NAs	2 800		

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

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2 800	Continued From page 35 and generally couple times a pay period ran with only two NAs instead of three NAs. LPN-C stated he cracked down on the NAs for turning off call lights before assisting resident. LPN-C stated R46 gets left to the end and staff leave tend to leave him and since R46 is patient R46 pays the price. LPN-C stated usually the DON and nurse manager aren't answering the call lights. R46's care plan dated 11/7/19, did not include R46's preference for bedtime at 6:00 p.m. RN-A nurse manager, stated on 11/7/19, at 2:26 p.m. R46 can go to bed at 6:00 p.m. and all staff knew that. RN-A stated R46's preference for bed time was not identified on R46's NA care sheet "as staff just know by word of mouth." DON stated on 11/7/19, at 2:45 p.m. R46 could go to bed at 6:00 p.m. as it was his preference. DON stated staff should accommodate this and follow residents' careplan. Facility policy Self Determination and Participation dated 7/25/16, indicated residents would be allowed to choose schedules that are consistent with their interest for daily routine including sleeping. The policy indicated to facilitate resident choices staff would gather information about residents' personal preferences upon initial assessment and periodically thereafter, and document these preferences in the medical record. 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.	2 800		

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2 800	Continued From page 36 R7 was observed on 11/4/19, at 6:55 p.m. sitting in his w/c near front desk. R7 stated he had to wait for help in the mornings to get his legs wrapped and get washed up. R7 stated night staff transferred him to his w/c at about 5 a.m.. R7 stated he asked the night nurse to wrap his legs at this time but the night nurse had told him she could not as she was too busy and the day nurse needed to wrap his legs. R7 stated he wanted his legs wrapped when he got up because his physician had told him it was better for his leg wound for his legs to be wrapped when getting up and the wound would heal faster. R7's Annual MDS dated 8/1/19, indicated R7's cognition was intact and included a diagnosis of diabetes and anxiety. R7's Annual MDS indicated R7 needed extensive staff assistance with dressing and with all activities of daily living. R7's MDS indicated R7 did not reject cares. R7's careplan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a venous ulcer on his lower right leg. R7's physician order dated 11/7/19, indicated R7 was to have "Compression devices to bilateral lower extremities" applied daily related to Lymphedema (swelling 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. R7 was observed on 11/7/19, at 8:07 a.m. sitting in his w/c in his room with his legs unwrapped,	2 800		

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2 800	Continued From page 37 waiting for his call light to be answered. R7 stated the nurse had not yet wrapped his legs and stated his legs should be wrapped when he got up, and stated he had to go to the toilet and had been 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 pad with drainage 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	2 800		

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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 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 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 nurse had told him she was "too busy" to wrap his legs.	2 800		

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2 800	Continued From page 39	2 800		

R7's care plan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a venous ulcer on his lower right leg.

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.

Facility policy Accommodation of Needs dated 7/25/16, indicated, facility's staff behaviors should assist resident in maintaining and/or achieving independent functioning, dignity and well-being and accommodate residents' individual needs and preferences.

Facility policy Self Determination and Participation dated 7/25/16, indicated each resident should be allowed to choose schedules with times of days for treatments.

NA-J stated on 11/12/19, at 9:42 a.m. that Hallway 200 did not have enough NAs working at a time. NA-J stated three were scheduled on hallway 200 but three were not enough to get everything done that needed to be done on a shift. NA-J stated Hallway 200 needed almost four NAs on a shift. NA-J stated residents were

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2 800	Continued From page 40 not getting toileted timely and were not getting bathing and showering 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	2 800		

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2 800	Continued From page 41 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 6:29 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 still activated. -At 6:31 p.m. R46 observed sitting in his w/c in his room waiting for assistance to bed with call light on.	2 800		

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2 800	Continued From page 42 -At 6:33 p.m. no call lights activated in hall 200 -At 6:33 p.m. R46 observed still waiting in his room to go to bed. -At 6:38 p.m. R10 and R54's call lights came on over their room doors. -At 6:40 p.m. R46 wheeled himself out of his room into hallway looking down hallway. RN-A told R46 she could get R46 hooked up to the lift while he was waiting. -At 6:44 p.m. R46 was observed sitting in his w/c in his room with RN-A present hooked up to the transfer lift. -At 6:47 p.m. NA walked into R46's room to assist RN-A to transfer R46 to bed. (R46 waited 41 minutes for staff assistance). -At 7:18 p.m. R46 stated to surveyor he wants to go to bed at 6:00 p.m. every evening. R46 stated he "waits that long all the time to go to bed, it's the usual." 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 bed. NA-B stated residents who needed less care at the last step of the process to bed went to bed first and the residents who required more steps last. NA-B stated there was not enough staff to wash residents up. NA-B stated that was generally the norm here at the facility. LPN-C stated on 11/6/19, at 2:21 p.m. showers could not be completed when only having two NAs. LPN-C stated last Sunday only had two NAs and generally couple times a pay period ran with only two NAs instead of three NAs. LPN-C stated he cracked down on the NAs for turning off call lights before assisting resident. LPN-C stated R46 gets left to the end and staff leave tend to leave him and since R46 is patient R46 pays the	2 800		

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2 800	Continued From page 43	2 800		

price. LPN-C stated usually the DON and nurse manager aren't answering the call lights.

R46's care plan dated 11/7/19, did not include R46's preference for bedtime at 6:00 p.m.

RN-A nurse manager, stated on 11/7/19, at 2:26 p.m. R46 can go to bed at 6:00 p.m. and all staff knew that. RN-A stated R46's preference for bed time was not identified on R46's NA care sheet "as staff just know by word of mouth."

DON stated on 11/7/19, at 2:45 p.m. R46 could go to bed at 6:00 p.m. as it was his preference. DON stated staff should accommodate this and follow residents' careplan.

Facility policy Self Determination and Participation dated 7/25/16, indicated residents would be allowed to choose schedules that are consistent with their interest for daily routine including sleeping. The policy indicated to facilitate resident choices staff would gather information about residents' personal preferences upon initial assessment and periodically thereafter, and document these preferences in the medical record.

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.

R7 was observed on 11/4/19, at 6:55 p.m. sitting in his w/c near front desk. R7 stated he had to wait for helpin the mornings to get his legs wrapped and get washed up. R7 stated night staff transferred him to his w/c at about 5 a.m.. R7 stated he asked the night nurse to wrap his legs

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

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2 800	Continued From page 44	2 800		

at this time but the night nurse had told him she could not as she was too busy and the day nurse needed to wrap his legs. R7 stated he wanted his legs wrapped when he got up because his physician had told him it was better for his leg wound for his legs to be wrapped when getting up and the wound would heal faster.

R7's Annual MDS dated 8/1/19, indicated R7's cognition was intact and included a diagnosis of diabetes and anxiety. R7's Annual MDS indicated R7 needed extensive staff assistance with dressing and with all activities of daily living. R7's MDS indicated R7 did not reject cares.

R7's careplan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a venous ulcer on his lower right leg.

R7's physician order dated 11/7/19, indicated R7 was to have "Compression devices to bilateral lower extremities" applied daily related to Lymphedema (swelling 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.

R7 was observed on 11/7/19, at 8:07 a.m. sitting in his w/c in his room with his legs unwrapped, waiting for his call light to be answered. R7 stated the nurse had not yet wrapped his legs and stated his legs should be wrapped when he got up, and stated he had to go to the toilet and had been waiting for 10-15 minutes already. Couple minutes later registered nurse (RN)-A walked into

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2 800	Continued From page 45 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 pad with drainage 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 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	2 800		

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	00758	A. BUILDING: _____ B. WING _____	C 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

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2 800	Continued From page 46 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 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 nurse had told him she was "too busy" to wrap his legs. R7's care plan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a venous ulcer on his lower right leg.	2 800		

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2 800	Continued From page 47 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. Facility policy Accommodation of Needs dated 7/25/16, indicated, facility's staff behaviors should assist resident in maintaining and/or achieving independent functioning, dignity and well-being and accommodate residents' individual needs and preferences. Facility policy Self Determination and Participation dated 7/25/16, indicated each resident should be allowed to choose schedules with times of days for treatments. NA-J stated on 11/12/19, at 9:42 a.m. that Hallway 200 did not have enough NAs working at a time. NA-J stated three were scheduled on hallway 200 but three were not enough to get everything done that needed to be done on a shift. NA-J stated Hallway 200 needed almost four NAs on a shift. NA-J stated residents were not getting toileted timely and were not getting bathing and showering 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	2 800		

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2 800	Continued From page 48 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. 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. R15's Care Area Assessment dated 12/7/18, indicated R15 required a secured unit due to her wanting to leave the facility and her memory loss. R15 had severe cognitive impairment and was unable to focus on what others were saying and recall what was said. R15's care plan printed on 11/6/19, indicated R15 had the potential to be physically aggressive related to dementia, and poor impulse control. R15 was bothered by loud noises. R15 was independent with ambulation and transfers. Interventions included: When R15 became agitated to intervene before agitation escalates,	2 800		

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2 800	Continued From page 49	2 800		

and guide away from source; Monitor and document any signs of R15 posing danger to self or others; Staff to be aware of R15 activity on the unit and keep R15 from residents that tend to invade her personal space; Cue and supervise as needed; Redirect when R15 seems confused or at risk for doing something that might cause distress; Monitor pacing, wandering or crying occurrences.

Review of Daily Staffing Sheets since July of 2019, revealed that the 300 memory unit was staffed during day and evening shift with two staff and the night shift one staff.

Review of R15 resident to resident altercations Vulnerable Adult (VA) - Incident reports revealed that R15 had four altercations since July 2019, with physical aggression with other residents.
-On 7/27/19, R15 was able to place her hands around R57's neck, and then reach out to hit R56 in the arm before staff could intervene. Report indicated that constant awareness of other residents and their behaviors was key to keeping everyone safe and secure.
-On 9/19/19, R15 and R55 were identified as unsupervised when licensed practical nurse (LPN) heard screaming and swearing. When LPN got within eye sight she found R15 and R55 punching each other in the face. The report also indicated that the second staff was off the unit at the time of the altercation.
-On 10/11/19, R55 was sitting in his wheelchair near the exit door when R15 was observed to walk up behind R55 and rub his head. R55 was seen to get up from his wheelchair and starting pushing R15 before staff could intervene.
-On 10/22/19, R55 was sitting in his wheelchair and R15 walked up and leaned in and said something to R55 then slapped him in the face

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2 800	Continued From page 50 with her open hand before staff could intervene. On 11/4/19, at 1:17 p.m. R15 was observed sitting at the table in common area with no staff present. At 1:20 p.m. licensed practical nurse (LPN)-F entered the common area just as R15 got up and walked down the hall to go enter a room. The common area was unsupervised for three minutes where R15 was sitting. On 11/4/19, at 5:21 p.m. R33 was observed sitting at a table yelling and R15 got up from her table walked over to R33 and stated something to her about a fist in your nose (unable to identify exactly what she said) then returned to her table. There were no staff present in the common area where these two residents were. At 5:25 p.m. kitchen staff entered the common area followed by a direct care staff. The common area was unsupervised for four minutes. On 11/4/19, at 5:31 p.m. R15 was observed up walking around and stopped to play with a resident's hair who was sitting at the table. There was no staff present in the common area. There was an activity staff in the next room visiting with another resident but unable to visually see R15. At 5:39 p.m., the activity staff entered the common area where R15 was located. The common area was unsupervised for six minutes. On 11/5/19, at 8:08 a.m. trained medication assistant (TMA)-A stepped out of a resident room and asked LPN-A for assistance. LPN-A left the common area where R15 was sitting and assisted the other staff. At 8:16 a.m., LPN-A returned to common area. The common area with residents sitting at tables and wheeling around were unsupervised for eight minutes. At 8:22 a.m. LPN-A left the common area where there were	2 800		

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

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2 800	Continued From page 51 residents including R15. At 8:30 a.m., kitchen staff arrived to common area. The common area was unsupervised for eight minutes. On 11/6/19, at 11:13 a.m. R15 was observed walking down the hallway and both staff were in another resident room. There was an activity staff in the common area but this staff was unable to visually see R15 and her whereabouts. On 11/7/19, at 7:51 a.m. LPN-K left common area with residents (including R15) present to assist the other staff in a room. At 7:56 a.m, LPN-K returned to the common area having left the area unsupervised for five 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. During interview on 11/4/19, at 5:25 p.m. NA-D stated that R15 always had aggressive behaviors and someone needed to watch her. NA-D stated that the nurse had medications to give on the memory unit and the 200 wing so that left NA-D alone at times and it was very hard to monitor everyone. NA-D stated that when she needs assistance with a resident the nurse was the one who helped and verifies that the residents were left unsupervised during those times. During interview on 11/5/19, at 8:53 a.m. TMA-A indicated monitoring R15 included watching her as R15 was very keen on another male resident. TMA-A stated "we cannot monitor all the residents when we are in getting residents up" and that was a safety concern.	2 800		

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2 800	Continued From page 52 The activity director (AD) was interviewed on 11/6/19, at 10:20 a.m. and stated that the activity department did not have set hours on the memory unit. AD stated the activity staff were not called to assist with monitoring residents on the memory unit while staff were completing cares as it was not part of the activities daily duties. The assistant director of nursing (ADON) was interviewed on 11/6/19, at 10:45 a.m. and indicates that R15 had quite a few incidents when she lashed out unprovoked. ADON stated staff kept an eye on R15, and R15 was supposed to be always in eye sight of staff. ADON stated if staff need to be in a room and could not monitor the common area they needed to radio for someone to come, as there needed to be someone monitoring at all times as there were other residents with behaviors. ADON agreed that R15 continued to have resident to resident altercations with no resolution. ADON stated she was unsure if anyone had looked at the times the altercation happened to see if there was a pattern. During interview on 11/6/19, at 11:12 a.m. DON indicated R15 was to be monitored but was not on one to one supervision as the facility did not have those resources. DON stated there were residents on that unit that required two staff assistance and during those times staff had to radio call for assistance to monitor residents in the common area. DON stated it was her expectation that residents were not left alone in the common area. On 11/6/19, at 2:09 p.m. RN-A indicated there should have always been one staff within eyes view of the hall and common area ideally. RN-A	2 800		

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2 800	Continued From page 53 stated there were times that did not happen as the nurse went to give pills but that was why staff carried radios so they can ask for help. On 11/7/19, at 8:45 a.m. licensed social worker stated staff were expected to be with R15 when she was in the common area. On 11/7/19, at 3:13 p.m. NA-I stated someone had to watch the residents when they were in the common area at all times because "you never know what they will do." Review of undated, Resident to Resident Altercation policy identified staff were to monitor residents for aggressive or inappropriate behaviors towards others. Review of the 9/27/19, Abuse Policy and Procedure indicated staff were to institute measures to address the needs of residents to minimize the possibility of abuse. The Abuse Prevention Program section indicated staff were committed to protect residents from abuse. The policy also indicated staff will identify occurrences and patterns of potential abuse and implement changes to prevent future occurrences.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		12/29/19

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

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2 830	Continued From page 54 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure heat registers were monitored for safe temperatures in resident rooms for 1 of 33 residents (R29) with baseboard heaters and failed to promptly respond to 1 of 1 resident (R44) report of shortness of breath, chest pain, and request to be transported to an Emergency Room for evaluation. In addition, the facility failed to comprehensively assess causative factors of falls and develop and implement appropriate interventions for 1 of 3 residents (R7) reviewed for falls and failed to perform leg treatments for 1 of 1 resident (R7) scheduled for daily leg wraps for lymphedema. The facility also failed to identify and comprehensively reassess continued use of a mechanical lift following a change in mobility and develop interventions for 1 of 1 resident (R30) reviewed accidents. Additionally, the facility failed to provide supervision to reduce resident to resident altercations for 5 of 5 residents (R15, R33, R55, R56, R57) in the memory unit. Furthermore, the facility failed to assess, develop and/or implement interventions to promote safe smoking and storage practices for 2 of 2 residents (R43, R25) reviewed for smoking hazards. and to perform leg treatments for 1 of 1 resident (R7) scheduled for daily leg wraps for lymphedema. Findings include:	2 830	Corrected	

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2 830	Continued From page 55 R29's Significant Change Minimum Data Set (MDS) assessment dated 9/9/19, identified severe cognitive impairment and hallucinations. R29's Significant Change MDS indicated R29 required extensive assistance of two staff for bed mobility, transfers, and toileting. In addition, R29's diagnoses were identified to include dementia, type 2 diabetes, depression and anxiety. R29's 11/6/19, care plan identified he had a self-care deficit related to aggressive behavior, cognitive loss associated with dementia, weakness, and incontinence. R29 required extensive assistance of up to two staff to turn and reposition in bed, extensive assistance of 1 staff to transfer with a sit to stand lift. R29 had weakness and limited physical mobility, and required extensive assist of one staff to move in his wheelchair. R29 had impaired communication related to cognitive loss associated with dementia. An incident report dated 11/1/19, at 4:30 p.m, indicated R29 had sustained a burn to his left leg. The incident report indicated R29's bed was in the lowest position next to the wall and was in contact with the electric baseboard heater when the resident sustained the burn. According to the incident report, the maintenance director (M) had determined the heater had an intermittent heating cycle. Further the maintenance director had reported at the time of his inspection, the heater was cool to the touch. R29's progress note dated 11/1/19, at 6:36 p.m., indicated R29 was discovered by staff with his left leg against the heat register in his room. The progress note indicated R29's leg had an 8 centimeters (cm) by 2.5 cm pink, area on the	2 830		

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

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2 830	Continued From page 56	2 830		

outer aspect of the left lower leg and indicated staff had applied a cold compress to the area. In addition, R29 was noted by staff to have been alert with no signs of pain. R29's physician was subsequently contacted and staff received an order for Silvadine (burn cream). R29's bed was immediately moved away from the wall with the heater. The Administrator, the director of nursing (DON) and M had determined the heater had been on long enough to expose R29's skin at the heating cycle. Following the incident, all rooms were checked to ensure beds were not placed directly against wall heaters, and staff education was provided to keep R29 away from the heater. In addition, the maintenance director was responsible to oversee periodic temperature monitoring of the wall heaters for the next 24 hours.

R29's physician progress note dated 11/4/19, identified R29 sustained a 2nd degree burn to the left lower leg. Staff were to continue Silvadine cream twice daily and to keep the wound clean and covered.

Observation on 11/5/19, at 1:34 p.m. identified R29's electric heater was located under an exterior window along the floor baseboard.

During observation and interview on 11/5/19, at 2:29 p.m. with M-A, R29's heater was observed to be an electric baseboard heater with a metal outer surface. At that time, the surfaces and and internal temperature of R29's heater were measured by M-A with an infrared thermometer to be 105 degrees Fahrenheit (F) on the outer metal cover. The top of the heater measured 119 degrees F, and the internal heating element was 123 degrees F. M-A agreed residents with fragile skin could be at risk for accidental burns when in

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

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2 830	Continued From page 57	2 830		

close contact with the heater. M-A stated they had determined R29's burn was caused by irradiation from the heated air inside the heater, exiting the vent. M-A said following R29's incident, he had checked all rooms on the 100 and 200 wings to ensure no other beds were in direct contact with those types of heaters. M-A stated he thought in order to cause a burn, the heater surface had to reach between 133 and 135 degrees F, and skin needed to be in contact with the heater for an extended period of time. M-A was unaware of the direction in the regulatory guidance that indicated burns could be sustained after exposure to temperatures over 120 degrees F in excess of 5 minutes. M-A was unable to find a manufacturer or serial number for any of the heaters to determine manufacturer's recommendations for safe heater use, and stated the heaters had been in use for at least 30 to 40 years. M-A further acknowledged the heaters were not checked for safety prior to the initial use in the fall of the year. In addition M-A verified staff had not been reminded to move any beds or items off, or away from, heaters. M-A stated he had monitored the temperatures of the room following the burn, but had not monitored heater surface temperatures.

During interview on 11/5/19, at 2:32 p.m. nursing assistant (NA)-B stated he had reported a concern related to hot heaters to the nurse manager, registered nurse (RN)-A, and DON a week before R29 was burned. NA-B stated R29's bed was too low and close to the heater. NA-B said he had raised the bed up a couple inches higher than the floor because the heater was hot, but stated he had not moved the bed away from the heater on the wall. NA-B said RN-A had advised him to place R29's bed in the lowest position, which unbeknownst to staff, put R29 in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT CANNON FALLS	300 NORTH DOW STREET CANNON FALLS, MN 55009

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2 830	Continued From page 58	2 830		

contact with the heater. NA-B stated he measured the temperature of all the room heaters after the incident and found 4 or 5 of room heaters above 120 degrees but was unable to remember which rooms.

During observation and interview on 11/7/19, at 10:13 a.m. licensed practical nurse (LPN)-E stated R29's bed was in the low position next to the heater at the time of the burn. LPN-E stated the burn was initially a large dark red area with no blister however, R29 developed a blister as a result of the burn. During observation at the time of the interview, the burn on R29's left lower leg appeared as an irregular 5 cm by 3 cm wound with bright red margins, with the inner wound bed 90 percent (%) covered with greenish/yellow tissue, and the outer 10 % of the wound bed was beefy red.

During interview with R29 on 11/7/19, at 10:15 a.m. said he had no pain in his lower left leg. R29 was unable to recall the events surrounding his burn, was aware of person only, and was not able to be interviewed further.

During interview on 11/8/19, at 2:10 p.m. DON denied being aware staff were concerned about the heater temperatures. DON stated there was no documentation of heater surfaces being too hot. DON confirmed the heater temperatures had been monitored initially after the burn. DON stated she expected all rooms to be monitored and stated staff were educated not to put beds next to the heater after R29's burn. However, DON stated she was unable to verify which staff had received education, and verified the revised policy was not reviewed after R29's incident.

Review of a 11/2/19, staff Meeting Sign In Sheet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 59	2 830		

identified staff on duty had received education to keep beds away from the heaters however, there was no evidence to determine whether staff who were not on duty at the time of the incident had been educated on heater safety.

During interview on 11/8/19, at 10:23 a.m. the medical director (MD) stated he was aware a resident had received a burn, but was not aware of the circumstances. MD stated the building was old, but replacing the heaters was likely not an option. However, confirmed preventative measures and policies should be in place to prevent burns from heaters. He expected the facility to develop a policy to establish a safe-zone around heaters to keep all beds, sheets, chairs out of the established safety zone to prevent burns and expected the management team to provide training to all staff about heater safety.

Review of the facility's 12/1/17, Room Temperature Policy identified resident beds and items were to be kept a safe distance from the baseboard heaters to prevent hazards. The policy did not identify what a safe distance or safe temperature was, but indicated all concerns were to be brought to management.

R44's Diagnoses Report printed on 11/7/19, included diagnoses of sepsis, pneumonia, hypoxemia, and urinary tract infection (UTI) on 10/29/19. R44 also had diagnoses of bipolar disorder, Major Depression Disorder, anxiety disorder, restlessness and agitation, dementia with behavioral disturbance, obesity, neuropathy, lower back pain and neuropathy of the lower extremities, pancreatic and splenic cysts, and a history of pulmonary embolism, lower extremity deep vein thrombosis, and UTIs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 60 R44's quarterly Minimum Data Sheet (MDS) on 10/7/19, identified R44's cognition was intact, had moderate depression, was delusional and verbally aggressive towards others, and rejected care on a daily basis. R44 required extensive assistance of one staff for bed mobility, He required extensive assistance of two staff to transfer and toilet and required supervision and setup for eating. R44 had pain rated 5/10 frequently and received scheduled pain medications. R44 had severe obesity and was five feet seven inches tall and weighed 272 pounds. R44 used antipsychotic, antidepressant, and diuretic medications. R44's care plan identified R44 required assistance of two staff to turn and reposition in bed. R44 used a full body lift and assistance of two staff to transfer. R44 required supervision during meals and sat in the assisted dining room. R44 had verbally abusive behaviors, was demanding, refused cares, and had ineffective coping skills. Staff anticipated needs, explained cares, allowed time to process information. R44 had impaired thought processes. Interventions were to keep consistent routines and caregivers as much as possible, and provide R44 with as many choices as possible. The care plan did not include interventions to address recent hospitalization for pneumonia, UTI and sepsis, and interventions were not included for continued use of antibiotic treatment. On 10/29/19, R44's hospital discharge note identified on 10/26/19, R44 was admitted to the hospital through the ED for hypoxemia and was diagnosed with pneumonia. Later the same day his temperature spiked and blood cultures were obtained. A urine culture identified a UTI, and R44 received IV antibiotics. The physician orders	2 830		

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 61 on 10/29/19, included Augmentin 875-125 mg 1 tablet 2 times daily for 10 days; and Levaquin 750 mg orally in the morning for pneumonia for 9 days. R44's electronic mediation administration record (EMAR) included nursing orders to assist R44 as needed with cares, and monitor vital signs with oxygen saturation, lung sounds, pain, behaviors, and therapy participation. The order was discontinued on 11/6/19. During interview on 11/7/19, at 7:43 a.m. the licensed practical nurse (LPN)-B stated she worked the night shift. She was completing her documentation from the night shift she had a resident fall, and the night was very hectic. R44 used the call light over 20 times during the shift. Throughout the night he was anxious, and complained of shortness of breath and chest pain. Staff continued to reposition and attempted to keep him comfortable. R44 refused to elevate the head of the bed and requested to use oxygen. R44's oxygen saturation was 94%. LPN-B told R44 oxygen was not an option because his oxygen level was normal, and starting oxygen could be detrimental. She told him she observed no visible signs of respiratory distress and reassured him he was ok. R44's lungs were wheezy, but had been since retuning from the hospital, and currently received antibiotics. LPN-B did not contact the physician or the DON because he frequently complained of shortness of breath, chest pain, and had requested to go the hospital. His vital signs were normal. She repositioned him and his oxygen saturation was within normal limits. She passed R44's concerns onto the oncoming nurse during change of shift report. During observation on 11/7/19 a 8:31 a.m. R44	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 62	2 830		

was seated in the dining room eating breakfast. Social worker (SW)-A was visiting with him. He stated good morning, and good bye, he stated he was fine, and declined to be interviewed. R44 had no signs of shortness of breath, and had not signs of anxiety.

On 11/7/19, at 12:15 p.m., an unidentified resident was observed being transported on a gurney out of the 200 wing by an ambulance crew.

On 11/7/19, at 12:57 p.m. LPN-D identified R44 was transported to the emergency department (ED) at 12:57 p.m. following complaints of chest pain, shortness of breath and wheezy lung sounds. He requested to go to the ED. His oxygen was at 94%. He complained of chest pain during the night. When he woke up the morning, he went to the dining room and did not complain of any symptoms. During breakfast, he stated he was not feeling well but wanted to finish eating. After breakfast, staff laid him down, and toileted him. His his vital signs were checked. He was given a nebulizer treatment at 10:48 a.m. which was ineffective. She notified the DON, and he was transferred to the ED to further evaluate his symptoms. He had complained of all of these symptoms through the current course of his illness, and was taking Levaquin and Augmentin 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 on 11/5/19 at 3:05 p.m..

Review of R44's progress notes on 11/6/19 and 11/7/19 did not include documentation of R44's reports of chest pain, wheezy lung sounds,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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

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2 830	Continued From page 63	2 830		

request for oxygen, or request to go to the hospital.

During interview on 11/8/19 at 10:50 a.m. LPN-D identified R44 returned from the ED yesterday, 11/7/19 after a few hours. He had no new issues, and no new orders.

On 11/8/19, at 1:53 p.m. the director of nursing (DON) was notified of R44's change in condition and instructed LPN-D to send him the ER. DON was not aware R44 had chest pain, anxiety, and shortness of breath during the night. She expected staff to contact her and initiate transfer the hospital as soon possible if residents have chest pain and shortness of breath. R44 was seen by MD Tuesday 11/5/19, for wheezing and increased his nebulizer treatments. R44 had a history of shortness of breath and had gastric bypass. Since his admission in January, his weight had increased from 171-200+ pounds. The physician was worried about aspiration pneumonia along with the weigh gain and shortness of breath. Staff normally called the DON when he had issues. She expected staff to call her and the physician any time changes in health status occur if a nurse had any questions or concerns regarding a resident's condition.

The ED visit report from 11/7/19, was requested on 11/8/19, at 2:00 p.m. following an interview with the DON, and not received for review.

The facility's Change in a Resident's Condition or Status policy (no date), indicated the nurse supervisor or charge nurse was to notify the resident's attending physician of changes including a change in condition when there has been a significant change in the resident's physical/emotional/mental status and if there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 64	2 830		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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

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2 830	Continued From page 65	2 830		

previous fracture" R30 indicated on 3/5/19, that "his leg was hit on the lift" and nursing assistants (NA) reminded to handle R30's left leg to ensure support during transfers. The file identified NA-K was one of the NA who had worked with R30 during that time.

R30's incident report dated 3/2/19, indicated R30 reported "the staff was transferring him in the hoyer one staff was in the back helping resident sit up straight the other staff guiding resident's leg, resident stated that the nursing assistant guiding his legs dropped his leg, causing pain."

R30's Emergency Medicine Provider Note dated 3/2/19, indicated R30 was seen for complaints of left leg pain and was diagnosed with a fractured tibia closed with noted surrounding sclerosis as well.

R30's annual MDS dated 9/16/19, identified R30 had intact cognition and diagnoses which included quadriplegia and anemia. The annual MDS indicated R30 required total dependence for his transfers.

R30's care plan revised 9/17/19, identified R10 was totally dependent on staff for all cares and directed staff to provide assist of two staff with full mechanical lift for transfers.

R30's Diagnosis report dated 11/8/19, indicated R30 had diagnoses which included squamous cell carcinoma of skin of left lower limb, right and left leg above the knee amputation.

R30's medical record lacked evidence of reassessment of transfers with the mechanical lift following his left lower extremity fracture on 2/15/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 66 DON was interviewed on 11/8/19, at 1:20 p.m. and stated it was her expectation for staff to communicate when a resident transfers were difficult and the resident would be reassessed for proper equipment and lift use. NA-K was interviewed via telephone on 11/12/19, at 4:17 p.m. and stated he had assisted with another NA transfer R30 with the mechanical lift. NA-K recalled he was controlling the lift while another NA was holding R30's leg due to R30 had his leg in a large brace. NA-K remembered the transfer having been difficult due to R30's leg brace and the support needed for R30's leg. NA-K stated during the transfer R30 "accidentally" hit his leg on the lift as R30 was unable to keep his leg positioned comfortably with the leg brace on when up in the lift. NA-K remembered R30 indicating his leg hurt from hitting his knee of the lift. NA-K was unable to recall if the nurse was notified regarding R30's leg hitting the lift and/or regarding R30's difficult transfers with the lift. The facility Safe Lifting and Movement of Residents Policy undated, indicated resident safety, dignity, comfort and medical condition would be incorporated into goals and decisions regarding the safe lifting and moving of residents. The policy indicated assessments of individual resident needs for transfer assistance was completed on an ongoing bases and staff would document resident transferring and lifting needs in the care plan. The policy indicated the assessment would include resident preference for assistance, resident degree of dependency, resident size, weight bearing ability, cognitive status, if the resident was cooperative with staff and resident goals. Furthermore, safe lifting and movement of residents was part of an overall	2 830		

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	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 67 safety program which involved employees in identifying problem areas. R7's Fall Risk Assessment dated 10/27/19, indicated R7 was a High fall risk. R7's Quarterly MDS dated 10/28/19, indicated R7's cognition was intact and had fallen more than two times since the last assessment completed on 8/1/19. R7's Quarterly MDS indicated R7 had diagnoses which included generalized muscle weakness and anxiety. R7's MDS indicated R7 needed extensive staff assistance with transfers and all activities of daily living and did not reject cares. R7 was observed on 11/4/19, at 6:55 p.m. sitting in his wheelchair (w/c) near the front desk, sitting upright in his w/c. R7 was observed on 11/7/19, at 8:07 a.m. sitting in w/c in his room with his call light on and stated he had to go to the bathroom. Couple minutes later Registered nurse (RN)-A entered R7's room with an EZ stand (mechanical lift) to transfer R7. R7 was observed on 11/7/19, at 1:33 p.m. sitting in w/c in his room leaning back in his chair, not sitting upright. R7 stated, "I fell to my knees last night, no hurt, it just happens." R7 explained he thought he was reaching for something but was unsure. NA-J stated on 11/12/19, at 9:42 a.m. R7 was a fall risk and had fallen recently. NA-J stated she thought R7 slides out of his chair and explained R7 always sits like he is sliding down and stated R7 sleeps in his w/c. NA-J verified R7's reacher was hanging up on the backside of R7's door out of reach in a plastic sleeve. NA-J stated she had never seen R7 use the reacher.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 68 R7 was observed on 11/12/19, at 1:33 p.m. sitting in his w/c in his room not sitting upright, leaning back. R7 stated he reaches for things and slides out of the w/c onto his knees on the floor and stated he had not gotten hurt from it. R7 stated he just forgets to use the reacher. R7 stated he thought he was sleeping in his w/c the last time he fell and he had seen the remote near his hand. R7 stated he thought his w/c was wide enough, but stated the seat of the w/c could be longer and the back up his w/c up further and then the w/c would be more comfortable. R7 stated maybe he needed a larger w/c and explained he had just fell forward. Review of R7's fall incident reports revealed: -R7 was found on the floor in his room on 6/11/19, at 11:49 p.m. Incident Report indicated R7 stated he was reaching when he slipped off his w/c to his knees. No intervention for root cause was indicated on the fall report. -R7 was found on the floor in his room on 6/18/19, at 9:45 a.m. on his knees. Incident Report indicated R7 stated he was reaching for something and slid out of his chair. The report indicated R7 was a big man who had difficulty sitting up straight. No intervention for root cause was indicated on the report. -R7 was transferred and right leg gave out and lowered to the floor to his knees on 6/27/19, per progress note. No Fall Incident Report received. -R7 was found on the floor in his room on 7/1/19, at 9:48 a.m. Incident Report indicated R7 stated he was reaching when he slipped out of his w/c. No intervention for root cause was indicated on the report. -R7 was found on the floor in his room on 9/2/19, at 6:30 p.m. Incident Report indicated R7 stated he had leaned too far forward and slipped out of	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 69	2 830		

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 R7 should use a reacher but stated she did not think there was a reacher in R7's room. DON stated she thought R7 falls were actually from him falling

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 70	2 830		

asleep in his w/c and not from him reaching, and explained R7 was always "sleepy". DON stated R7 had seen a neurologist for right side upper and lower symptoms of numbness and was going to be scheduled for additional testing.

RN-A, nurse manager stated on 11/8/19, at 1:00 p.m. she was unavailable to go over R7's fall reports and to talk with DON about R7's falls.

DON stated on 11/8/19, at 1:02 p.m. the IDT met daily Monday through Friday and discussed residents' falls. DON stated R7 had just fallen yesterday and IDT was trying to come up with an appropriate intervention for his falling for reaching. DON stated she was not aware if therapy had evaluated R7 for fitting of his w/c. DON stated the nurse managers were responsible for care planning and implementing the fall interventions. DON stated staff should follow residents' care plans.

Facility policy Falls -- Clinical Protocol undated, indicated staff would evaluate resident fall and attempt to define possible cause within 24 hours of the fall and identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The fall policy indicated if underlying causes cannot be readily identified or corrected, staff were to try various relevant interventions, based on assessment of the nature of the the fall until falling reduces or stops or until a reason is identified for its continuation.

R7 leg wrap treatment
R7 was observed on 11/4/19, at 6:55 p.m. sitting in his wheelchair (w/c) near front desk. R7 stated he had to wait for help in the mornings to get his legs wrapped and get washed up. R7 stated night

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 71 staff transferred him to his w/c at about 5 a.m.. R7 stated he asked the night nurse to wrap his legs at this time but the night nurse had told him she could not as she was too busy and the day nurse needed to wrap his legs. R7 stated he wanted his legs wrapped when he got up because his physician had told him it was better for his leg wound for his legs to be wrapped when getting up and the wound would heal faster. R7's Annual MDS dated 8/1/19, indicated R7's cognition was intact and included a diagnosis of diabetes and anxiety. R7's Annual MDS indicated R7 needed extensive staff assistance with dressing and with all activities of daily living. R7's MDS indicated R7 did not reject cares. R7's careplan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a venous ulcer on his lower right leg. R7's physician order dated 11/7/19, indicated R7 was to have "Compression devices to bilateral lower extremities" applied daily related to Lymphedema (swelling 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. R7 was observed on 11/7/19, at 8:07 a.m. sitting in his w/c in his room with his legs unwrapped, waiting for his call light to be answered. R7 stated the nurse had not yet wrapped his legs and stated his legs should be wrapped when he got up, and stated he had to go to the toilet and had been	2 830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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 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	2 830		

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 73	2 830		

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 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 nurse had told him she was "too busy" to wrap his legs.

R7's care plan dated 6/27/19, indicated R7 was to have compression devices applied to both lower legs applied in the morning and taken off at bedtime. R7's careplan indicated R7 had a

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 74 venous ulcer on his lower right leg. 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. Facility policy Accommodation of Needs dated 7/25/16, indicated, facility's staff behaviors should assist resident in maintaining and/or achieving independent functioning, dignity and well-being and accommodate residents' individual needs and preferences. Facility policy Self Determination and Participation dated 7/25/16, indicated each resident should be allowed to choose schedules with times of days for treatments. 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. R15's Care Area Assessment dated 12/7/18,	2 830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 75 indicated R15 required a secured unit due to her wanting to leave the facility and her memory loss. R15 had severe cognitive impairment and was unable to focus on what others were saying and recall what was said. R15's care plan printed on 11/6/19, indicated R15 had the potential to be physically aggressive related to dementia, and poor impulse control. R15 was bothered by loud noises. R15 was independent with ambulation and transfers. Interventions included: When R15 became agitated to intervene before agitation escalates, and guide away from source; Monitor and document any signs of R15 posing danger to self or others; Staff to be aware of R15 activity on the unit and keep R15 from residents that tend to invade her personal space; Cue and supervise as needed; Redirect when R15 seems confused or at risk for doing something that might cause distress; Monitor pacing, wandering or crying occurrences. Review of Daily Staffing Sheets since July of 2019, revealed that the 300 memory unit was staffed during day and evening shift with two staff and the night shift one staff. Review of R15 resident to resident altercations Vulnerable Adult (VA) - Incident reports revealed that R15 had four altercations since July 2019, with physical aggression with other residents. -On 7/27/19, R15 was able to place her hands around R57's neck, and then reach out to hit R56 in the arm before staff could intervene. Report indicated that constant awareness of other residents and their behaviors was key to keeping everyone safe and secure. -On 9/19/19, R15 and R55 were identified as unsupervised when licensed practical nurse	2 830		

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 76	2 830		

(LPN) heard screaming and swearing. When LPN got within eye sight she found R15 and R55 punching each other in the face. The report also indicated that the second staff was off the unit at the time of the altercation.
-On 10/11/19, R55 was sitting in his wheelchair near the exit door when R15 was observed to walk up behind R55 and rub his head. R55 was seen to get up from his wheelchair and starting pushing R15 before staff could intervene.
-On 10/22/19, R55 was sitting in his wheelchair and R15 walked up and leaned in and said something to R55 then slapped him in the face with her open hand before staff could intervene.

On 11/4/19, at 1:17 p.m. R15 was observed sitting at the table in common area with no staff present. At 1:20 p.m. licensed practical nurse (LPN)-F entered the common area just as R15 got up and walked down the hall to go enter a room. The common area was unsupervised for three minutes where R15 was sitting.

On 11/4/19, at 5:21 p.m. R33 was observed sitting at a table yelling and R15 got up from her table walked over to R33 and stated something to her about a fist in your nose (unable to identify exactly what she said) then returned to her table. There were no staff present in the common area where these two residents were. At 5:25 p.m. kitchen staff entered the common area followed by a direct care staff. The common area was unsupervised for four minutes.

On 11/4/19, at 5:31 p.m. R15 was observed up walking around and stopped to play with a resident's hair who was sitting at the table. There was no staff present in the common area. There was an activity staff in the next room visiting with another resident but unable to visually see R15.

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	00758	A. BUILDING: _____ B. WING _____	C 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

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2 830	Continued From page 77 At 5:39 p.m., the activity staff entered the common area where R15 was located. The common area was unsupervised for six minutes. On 11/5/19, at 8:08 a.m. trained medication assistant (TMA)-A stepped out of a resident room and asked LPN-A for assistance. LPN-A left the common area where R15 was sitting and assisted the other staff. At 8:16 a.m., LPN-A returned to common area. The common area with residents sitting at tables and wheeling around were unsupervised for eight minutes. At 8:22 a.m. LPN-A left the common area where there were residents including R15. At 8:30 a.m., kitchen staff arrived to common area. The common area was unsupervised for eight minutes. On 11/6/19, at 11:13 a.m. R15 was observed walking down the hallway and both staff were in another resident room. There was an activity staff in the common area but this staff was unable to visually see R15 and her whereabouts. On 11/7/19, at 7:51 a.m. LPN-K left common area with residents (including R15) present to assist the other staff in a room. At 7:56 a.m, LPN-K returned to the common area having left the area unsupervised for five 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. During interview on 11/4/19, at 5:25 p.m. NA-D stated that R15 always had aggressive behaviors and someone needed to watch her. NA-D stated that the nurse had medications to give on the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 78	2 830		

memory unit and the 200 wing so that left NA-D alone at times and it was very hard to monitor everyone. NA-D stated that when she needs assistance with a resident the nurse was the one who helped and verifies that the residents were left unsupervised during those times.

During interview on 11/5/19, at 8:53 a.m. TMA-A indicated monitoring R15 included watching her as R15 was very keen on another male resident. TMA-A stated "we cannot monitor all the residents when we are in getting residents up" and that was a safety concern.

The activity director (AD) was interviewed on 11/6/19, at 10:20 a.m. and stated that the activity department did not have set hours on the memory unit. AD stated the activity staff were not called to assist with monitoring residents on the memory unit while staff were completing cares as it was not part of the activities daily duties.

The assistant director of nursing (ADON) was interviewed on 11/6/19, at 10:45 a.m. and indicates that R15 had quite a few incidents when she lashed out unprovoked. ADON stated staff kept an eye on R15, and R15 was supposed to be always in eye sight of staff. ADON stated if staff need to be in a room and could not monitor the common area they needed to radio for someone to come, as there needed to be someone monitoring at all times as there were other residents with behaviors. ADON agreed that R15 continued to have resident to resident altercations with no resolution. ADON stated she was unsure if anyone had looked at the times the altercation happened to see if there was a pattern.

During interview on 11/6/19, at 11:12 a.m. DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 79 indicated R15 was to be monitored but was not on one to one supervision as the facility did not have those resources. DON stated there were residents on that unit that required two staff assistance and during those times staff had to radio call for assistance to monitor residents in the common area. DON stated it was her expectation that residents were not left alone in the common area. On 11/6/19, at 2:09 p.m. RN-A indicated there should have always been one staff within eyes view of the hall and common area ideally. RN-A stated there were times that did not happen as the nurse went to give pills but that was why staff carried radios so they can ask for help. On 11/7/19, at 8:45 a.m. licensed social worker stated staff were expected to be with R15 when she was in the common area. On 11/7/19, at 3:13 p.m. NA-I stated someone had to watch the residents when they were in the common area at all times because "you never know what they will do." Review of undated, Resident to Resident Altercation policy identified staff were to monitor residents for aggressive or inappropriate behaviors towards others. Review of the 9/27/19, Abuse Policy and Procedure indicated staff were to institute measures to address the needs of residents to minimize the possibility of abuse. The Abuse Prevention Program section indicated staff were committed to protect residents from abuse. The policy also indicated staff will identify occurrences and patterns of potential abuse and implement changes to prevent future occurrences.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 80 R43's annual MDS dated 10/3/19, identified R43 was current tobacco user and had intact cognition. R43's annual MDS indicated R43 diagnoses included anemia, end stage renal disease, peripheral vascular disease and diabetes mellitus. Furthermore, R43's MDS indicated R43 required supervision and/or oversight with activities of daily living. R43's Smoking Review dated 10/15/19, identified R43 did not currently smoke, however intended to smoke. The review indicated R43 had a history of smoking related incidents which included burning self, burning clothing, burning furniture, dropping ashes on self" and indicated R43 "must wear smoking apron" and utilize cigarette holder when smoking. The review indicated staff reviewed the policy related to smoking times and storage of smoking materials with R43, however lacked evidence regarding safe storage of smoking materials. R43's Care Plan revised on 10/23/19, indicated R43 was currently a smoker and directed staff to assist R43 in wearing smoking apron every time he went to smoke, instruct about smoking risks and hazards, smoking cessation aids, instruct facility policy on smoking: locations, times, safety concerns, notified charge nurse immediately if it was suspected R43 had violated facility smoking policy, observed clothing and skin for signs of cigarette burns, R43 could smoke unsupervised, using a cigarette holder and smoking apron on his lap. R43 was able to light his own cigarette, keep lighter, smoking supplies and roller at bedside. R43 Progress Note (PN) were reviewed from 8/30/19, through 10/29/19, and revealed the	2 830		

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

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2 830	Continued From page 81 following: -On 8/30/19, the PN indicated the Director of Nursing (DON) observed two open areas on R43's inner index finger and middle finger. R43 was identified as a smoker and used "index and middle finger to hold cigarette." A subsequent PN dated 8/30/19, indicated R43 was noted with burn mark on his hand that was related to smoking, R43 was deemed unsafe to smoke without supervision on the property. The PN indicated R43 did not wish to stop smoking and agreed to smoke off of the property; -On 9/10/19, the PN indicated Social Worker (SW) talked with R43 about not being safe to smoke and offered a holder to protect R43's fingers and wearing an apron to protect R43 from burning clothing; -On 9/11/19, the PN indicated R43 was assessed to have been safe to smoke with the following protective devices cigarette holder and smoking apron, R43 had agreed to use both of the devices; -On 9/19/19, the PN indicated R43 was observed to have been outside smoking "with out his special gloves or smoking apron per facility agreement" R43 stated "I just got back". R43 was educated to wear the smoking gloves and apron for safety reasons; -On 9/20/19, the PN indicated R43 lost his smoking privileges due to not wearing his safety devices for smoking; -On 10/29/19, the PN indicated R43 was given a smoking ring for safety and agreed to use it when smoking. R43 was observed on 11/6/19, at 8:27 a.m.. in the designated smoking area outside of the building, R43 removed his cigarette and lighter from his jacket and lit his cigarette. R43 was observe without a smoking apron and/ or	2 830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 82	2 830		

cigarette holder or ring. R43 was seated in his wheelchair while smoking and was observed to ash on the ground between his legs. While R43 was ashing his cigarette R43 was observed to drop white ashes on to his pants. R43 did not have cigarette burns on his clothes, hand and/ or wheelchair.

R43 was interviewed on 11/6/19, at 8:50 a.m. and stated that "the staff does not tell me or give me any instruction about going out to smoke." R43 stated he did not have cigarette ring or holder and unable to locate his smoking apron. R43 indicated it was ok for him to leave his cigarette and lighter unlock on his bedside table. At the time of the interview R43 was observed to have had his cigarette, tobacco and lighter unlocked on top of his bedside table.

NA-C was interviewed on 11/6/19, at 8:41 a.m. and stated R43 smoked independently and NA-C was unaware of any supplies R43 needs to smoke.

LPN-D was interviewed on 11/6/19, at 11:08 a.m. and stated R43 never notified anyone when he went to smoke. LPN-D indicated R43 was supposed to go out with a smoking apron and cigarette holder. LPN-D stated when she would see R43 without a smoking apron, she would remind him he needed one.

DON was interviewed on 11/08/19, at 1:14 p.m. and stated that it was her expectation for staff and residents to follow the care plan. DON explained R43's smoking ring was on order due to his cigarette was difficult to find a right ring that fit. DON confirmed R43 should have had a cigarette holder in his room available for use. DON stated R43 had been non-complaint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 83	2 830		

regarding use of his smoking apron and cigarette holder and indicated staff would spot check to make sure R43 smoked safely.

The facility Smoking Policy-Residents revised 11/8/19, indicated any residents or visitor who did not comply with rules regarding smoking would be asked to restrict and/ or forfeit their smoking privileges. Policy indicated smoking assessment would be completed before resident could smoke and " Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring fire retardant smoking aprons) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues ...Lighters MUST be returned to nurse's station when coming in from smoking."

R25's MDS dated 9/11/19, identified diagnoses that included depression and end stage liver disease. R25's MDS indicated R25 was cognitively intact.

R25 was interviewed on 11/6/19, at 11:49 a.m. and stated he smoked a half pack of cigarettes per day. R25 indicated the rules were smokers had to stay in a specific area outside which was away from the entrance. R25 stated he had his cigarettes and lighter in a shelf in his room.

R25 was interviewed again on 11/7/19, at 11:29 a.m. and stated he rolled his own cigarettes with supplies kept in his room. R25 indicated that he also kept his lighter in his room. The supplies and lighter were visible on a shelf under a refrigerator. The lighter was noted to be a refillable type. R25 brought out lighter fluid kept in an unlocked drawer of a bedside table. R25 stated he had not been told he could only use disposable lighters.

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

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

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2 830	Continued From page 84 LPN-E was interviewed on 11/7/19, at 11:29 a.m. and verified that residents were allowed to keep cigarettes and lighters in their rooms and did not need to keep the supplies locked up. LPN-E stated the policy was changed from requiring cigarette supplies from being locked at the nursing station to allowing residents to keep in their rooms because there was a complaint made to the ombudsman who indicated the materials were property of the residents. R25's care plan dated 10/14/19, indicated R25 was a smoker and outlined the following: The resident will not suffer injury from unsafe smoking practices through the review date; Instruct resident about smoking risks and hazards and about smoking cessation aids that are available; Instruct resident about the facility policy on smoking: locations, times, safety concerns; Monitor oral hygiene; Notify charge nurse immediately if it is suspected resident has violated facility smoking policy; Observe clothing and skin for signs of cigarette burns; The resident can smoke unsupervised; The resident is able to: (light own cigarette, keep lighter at bedside....). R25 signed a smoking policy on 9/20/19. The policy dated 9/20/19, indicated that lighters must be in a locked box at the nurses' station, that all smoking products will be stored in the locked box and the residents were not permitted to keep cigarettes or supplies in their possession. Social Worker (LSW)-A was interviewed on 11/8/19, at 8:42 a.m. and confirmed that the current smoking policy could not be enforced because cigarettes and supplies were considered personal property of the residents per the ombudsman. LSW-A also stated if the resident had holes in their clothes, they could not be	2 830		

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2 830	Continued From page 85 forced to wear an apron. Residents were required to have a smoking assessment and if deemed to be unsafe, the privilege was taken away. The residents could not have a cigarette until they were determined to be safe. LSW-A was not aware that R25 kept lighter fluid in his room. LSW-A stated she did not do room searches, but indicated the lighter fluid would be taken away. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review, revise policies and procedures regarding comprehensive assessment of resident transfers, smoking assessment and supervision. The DON (Director of Nursing) or designee could review policies and procedures for resident preference for timeframe for staff assistance with treatments and change of condition. Facility staff could be educated on these policies and procedures. The administrator, DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	2 890		12/29/19

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2 890	Continued From page 86 A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion exercises for 1 of 2 residents (R4) reviewed for limited range of motion. Findings include: R4 was observed on 11/4/19, at 6:29 p.m. sitting in her Broda chair in her room with her left hand fingers curled in. R4's Quarterly MDS dated 10/23/19, indicated R4's cognition was impaired, was totally dependent on staff assistance for dressing and personal hygiene and did not reject cares. R4's Quarterly MDS indicated R4 had functional limitation in ROM with both upper and lower extremities. Finger contractures were not identified on the quarterly assessment. R4's Care Area Assessment (CAA) dated 1/11/19, indicated R4 had limited ROM, bilateral shoulder arthritis and contracture. R4's CAA did not indicate location of the contracture and did not indicate ROM exercises were to be performed. R4's Significant Change Minimum Data Set (MDS) dated 7/26/19, indicated R4's cognition was impaired and R4 had diagnoses of Arthritis,	2 890	Corrected	

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2 890	Continued From page 87	2 890		

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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2 890	Continued From page 88	2 890		

could not straighten our her fingers and was concerned about it. R4 stated she did not want the left fingers to get any worse. R4 tried to open up her left hand, but could not stretch out her fingers all the way open.

Licensed practical nurse (LPN)-D stated on 11/7/19, at 1:40 p.m. she had not assessed R4's left fingers for contractures.

Nursing assistant (NA)-J stated on 11/7/19, at 1:40 p.m. NAs did not perform ROM or exercises for R4's left hand. NA-J pulled out her NA care sheet and confirmed ROM/exercises was not identified on the care sheet for R4.

Registered nurse (RN)-A, who was also nurse manager, stated on 11/7/19, at 1:42 p.m. R4 had a history of stroke and frozen left shoulder and guarded her left arm because of pain and did not use her left hand. RN-A stated R4 did not receive restorative therapy. RN-A stated ROM could be done with R4 for comfort but was presently not being done by staff. RN-A called on the telephone and put therapy director (TD) on speaker and asked if R4 had been seen by therapy. TD stated therapy had worked with R4 in the spring for passive ROM for the upper part of body for pain management. TD stated therapy had not identified hand/finger contractures for R4 and R4 was able to open both hands. TD stated therapy could evaluate and provide three visits she though. RN-A stated she would e-mail hospice for R4 to be evaluated by therapy for ROM for her left fingers contractures.

R4 was observed on 11/8/19, at 9:52 a.m. sitting in her Broda chair in her room. R4 stated a couple of staff had come and talked to her about her left hand fingers. R4 stated she did not know

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

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2 890	Continued From page 89 what had been decided yet but wanted ROM to help with the fingers not getting worse. R4 stated she was not interested in having a hand splint only wanted ROM exercises. Nursing assistant (NA)-J stated on 11/12/19, at 9:43 a.m. that R4 lets her wash her hands. NA-J stated R4 could open up some of her fingers on the left hand, but not all the way open. Hospice nurse (HN) stated on 11/8/19, at 11:32 a.m. she was here to see R4. HN stated R4 kept her fingers on her left hand curled and stated R4 could open up her fingers with some pain. HN stated she had not noticed R4 could not open her fingers up all the way and would assess and evaluate for contractures and ROM. HN stated on 11/12/19, at 9:31 a.m. she had now identified contractures for R4's left fingers. HN stated R4 could only partially open up her left fingers and was going to have therapy evaluate and implement ROM and splint with some wear time. R4's progress note dated 11/8/19, indicated HN had discussed with RN-A about ordering an Occupational Therapy evaluation for R4's left hand contractures to see what could be done to increase ROM and stiffness and order was written. Director of nursing (DON) stated on 11/8/19, at 1:50 p.m. she was not aware of R4's left fingers contractures. DON stated on 11/12/19, at 11:48 a.m. R4 should have been assessed for contractures before survey process.	2 890		

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2 890	Continued From page 90 Facility policy Rehabilitative Nursing Care undated, indicated each resident admitted would receive Rehabilitative nursing care and would be developed and coordinated through the resident's care plan. The policy indicated residents would be assisted with exercises between visits of the therapists and would be assisted with their routine range of motion exercises. SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to	2 900		12/29/19

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2 900	Continued From page 91 promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ongoing monitoring, comprehensive assessment, and implementation of interventions to promote healing of a facility acquired right and left stump pressure ulcers for 1 of 2 residents (R43) reviewed for pressure ulcers. Finding include: R43's annual Minimum Data Set (MDS) dated 10/3/19, identified R43 had intact cognition and diagnoses included anemia, end stage renal disease, peripheral vascular disease and diabetes mellitus. The annual MDS indicated R43 had one unstageable (not stage able due to coverage of wound bed by slough and/or eschar) pressure ulcer. The MDS identified R43 was at risk of developing pressure ulcers and interventions included nutrition or hydration, pressure ulcer care, applications of ointments/ medications other than to feet. The MDS further indicated R43 required supervision and/or oversight with activities of daily living. R43's Progress Notes (PN) and Weekly Wound Assessment (WWA) were reviewed from 10/16/19, through 11/6/19, and revealed the following: -The WWA dated 10/16/19, indicated R43 had pressure area to the front of right "lower leg" which was noted as a new area, however R43 WWA identify "no" R43's care plan was not reviewed or updated. A subsequent WWA dated	2 900	Corrected	

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2 900	Continued From page 92 10/16/19, indicated R43 had a pressure area to the front of left "lower leg" wound was previously healed and re-injured related to artificial legs use, however R43 WWA identify "no" R43's care plan was not reviewed or updated. An additional WWA dated 10/16/19, indicated R43 had a second pressure area to the front of the left "lower leg" which was noted as a new area, however R43 WWA identify "no" R43's care plan was not reviewed or updated. Additionally, WWA dated 10/16/19, indicated R43 had a pressure area behind of R43 left knee which had noted improvement. Furthermore, WWA dated 10/16/19, indicated R43 had a second pressure area behind of R43 left knee which had noted improvement; -The PN dated 10/23/19, identified R43 was approached before leaving for dialysis to complete wound assessment of R43's lower stumps and indicated R43 had both of his artificial legs on, and would not take them off for an assessment; -The PN dated 10/28/19, indicated R43 was getting ready to go to dialysis, floor nurse requested Registered Nurse (RN)-A to "observe" bilateral stumps as R43 did not have his artificial legs on. "Bilateral stumps observed. Pressure area to right lower front leg intact, blanchable redness. Areas behind left knee covered with serous crust, no drainage, erythema or inflammation. Small open area to top of left leg above knee. Skin prep applied, adhesive foam bordered dressing applied to right lower leg and behind left knee." However, the PN lack evidences of measurement and evaluation of current intervention and treatments; -The PN dated 10/30/19, indicated R43 was seated in the wheelchair with artificial legs on and was approached for wound observation. The PN indicated R43 declined, staff re-approached R43	2 900		

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2 900	Continued From page 93 prior to leaving for dialysis and R43 declined again; -The PN dated 10/31/19, indicated R43 wound care needed to be done on every Monday and Thursday, however, the PN indicated R43 "was outside every time staff wanted to do Tx [treatment];" -The PN dated on 11/6/19, indicated R43 refused observation of both of the stumps, due to R43 had both of his artificial legs on and did not want to take them off. The PN indicated R43 said "they are fine and don't need anything anymore." R43's medical record was further reviewed and lacked evidence of weekly wound monitoring to include measurements, evaluations of interventions, and consistent treatments to promote healing of the wound. In addition, R43 medical record lack evidence of risk and benefit discussed with R43 regarding refusal of wound treatment and assessment. R43's care plan date initiated on 9/27/19, indicated R43 was at risk for skin breakdown and 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 treatment was on Wednesday and Sunday: apply skin prep and cover with adhesive foam dressing. However, R43 care plan lack evidences of R43 preference regarding wound assessment and treatment. In addition, R43 care plan lacked direction to staff regarding refusal of wound assessment and treatment.	2 900		

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2 900	Continued From page 94 R43's Pressure Ulcers Care Area Assessment (CAA) dated 10/17/19, identified R43 had an unstageable pressure ulcers and bilateral lower extremities amputation and was non-compliance with medical recommendations. The CAA directed staff to assist with placement of shrinker socks, insulin management and ambulation with artificial legs. R43 was interviewed on 11/07/19, at 8:31 a.m. and stated staff usually put the dressing on, however indicated the staff had not observed his wound recently. R43 stated he would not refuse wound care, however preferred wound care was completed prior to putting both artificial legs on for the day. RN-A was interviewed on 11/07/19, at 8:41 a.m. and stated R43 wound assessment was supposed to be done daily however R43 often refused. RN-A stated R43 was "very resistance and often refused" to take artificial legs off for wound assessment. RN-A was observed on 11/07/19, at 9:11 a.m. while doing dressing change for R43. RN-A assessed the wound on R43's right stump which measured 0.5 centimeters (cm) by 1.2 cm and described as "superficial, dry." RN-A confirmed that R43 right stump was supposed to have had a dressing on at all times, however, verified R43 wound was not covered prior to the dressing change. RN-A assessed the wound behind R43 left knee which measured 1.5 cm by 1.5 cm and described "no depth, very superficial, resurface very light pink." RN-A confirmed R43 had no additional pressure areas at that time. R43 and RN-A were interviewed on 11/07/19, at 9:28 a.m. and stated he did not want to take	2 900		

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2 900	Continued From page 95	2 900		

artificial legs on and off for wound assessment on dialysis day and told RN-A he preferred the wound assessment to be done before. R43 stated to RN-A "you always" wait until "I" was ready to leave for dialysis with my legs on. RN-A answered, "I know it's my bad."

The director of nursing (DON) was interviewed on 11/8/19, at 1:00 p.m. and stated they had a nurse practitioner who was a wound certified nurse and rounded weekly with RN-A to complete weekly wound assessment. DON also stated that she expected a dressing over a pressure ulcer wound and if it wasn't there, it needed to be replaced by staff as soon as possible. DON stated that R43 was always the first one on the list for his weekly wound assessment, however he would often refuse.

The facility Pressure Ulcer Risk Assessment policy undated, indicated "Assessment 3 ...Monitoring: a. Staff will perform routine skin inspections (with daily care). b. Nurses are to be notified to inspect the skin if skin changes are identified. c. Nurses will conduct skin assessment at least weekly to identify changes ...Steps in the Procedure 4. Once inspection of skin is completed proceed to the Admission Assessment or Weekly Skin Integrity tool (depending on whether this is a new admission or an existing resident) and complete documentation of findings ... 6. Proceed to care planning and interventions individualized for the resident and their particular risk factors ...Documentation: 9. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risk of refusing the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal."

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2 900	Continued From page 96 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced	2 915		12/29/19

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	00758	A. BUILDING: _____ B. WING _____	C 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

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2 915	Continued From page 97 by: Based on observation, interview and document review, the facility failed to comprehensively assess and ensure the necessary cares and services were developed regarding bladder incontinence for 1 of 1 resident (R35) who was able to carry out some of her ADL activities. Findings include: R35 was observed on 11/7/19, at 7:10 a.m. with her call light on. At 7:19 a.m. nursing assistant (NA)-C entered R35's room. R35 was observed to be lying in bed with a strong urine odor coming from R35's bed. R35 requested to go to the bathroom as NA-C removed R35's blanket NA-C indicated R35 was lying in a urine soaked bed. NA-C indicated R35's "entire bed was "wet" from urine and needed to be changed. NA-C assisted R35 to turn onto her side and indicated R35 was wet with urine from the middle of the thighs up to the middle of the back. NA-C indicated the urine was dried to the bedding around the edges and the bedding was cold and wet. R35 was interviewed on 11/7/19, at 7:35 a.m. and stated she had asked to go to the bathroom around midnight, however indicated the staff whom answered her call light turned her call light off and did not respond and walked out of the room. R35 stated she went back to sleep and indicated it "only happens sometimes" when staff would not assist R35 to the bathroom. NA-C was interviewed on 11/7/19, at 7:40 a.m. and stated there were certain days of the week when residents would be found in bed that were wet, however indicated wet beds was not uncommon.	2 915	Corrected	

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2 915	Continued From page 98 R35 was observed on 11/7/19, at 8:31 a.m. and told the administration during breakfast that she had an accident during the night. R35 indicated "she was soaking wet" and staff should have been on the schedule to help people "so that they don't lay in bed soaking wet." R35's annual Minimum Data Set (MDS) dated 9/26/19, indicated R35 had moderate cognitive impairment and diagnoses which included manic depression and diabetes mellitus. The MDS indicated R35 required extensive assistance with ADL and did not have a toileting program. The MDS further indicated R35 was occasionally incontinent or urine and bowel. R35's care plan revised 10/2/19, identified R35 had a self-care performance deficit and directed staff to assist for toileting, occasional incontinent of bladder, change when soiled and as needed. R35's care plan revised 10/10/19, identified R35 had occasional bowel and bladder incontinence related to need for staff assistance with toileting tasks and use of medications and directed staff to change as needed when soiled, pericare with each incontinent episode and monitor for signs and symptoms of urinary tract infection. R35's Urinary Incontinence Care Area 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 "entire 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,	2 915		

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2 915	Continued From page 99 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. The 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 toileting, prompted voiding or other interventions to try to manage incontinence. The policy further indicated incontinence care should have been individualized at night in order to maintain comfort and skin integrity and minimize sleep disruption. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review, revise policies and procedures bladder assessment and toileting care plan. Facility staff could be educated on these policies and procedures. DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One	2 915		

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2 915	Continued From page 100 (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 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. Findings include: R44 was observed on 11/8/19, at 7:40 a.m. with his call light on. At 7:59 a.m. R44 indicated he had been on the bed pan waiting for "30 to 45 minutes" and needed assistance to get off of the bed pan as he had "been done for a long time." At 8:05 a.m. nursing assistant (NA)-A was observed to answer R44's call light when entering R44's room R44 told to NA-A he had been "waiting more than I should." R44 was observed to have had a bowel movement NA-A provided pericares and assisted R44 off of the bed pan. R44 also said to NA-A that he had been waiting "45 minutes" and NA-A replied, "we are working	2 920	Corrected	12/29/19

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2 920	Continued From page 101 as fast as the two of us can." R44's quarterly Minimum Data Set (MDS) dated 10/7/19, identified R44 had intact cognition and diagnoses which included dementia and manic depression. The quarterly MDS indicated R44 required extensive assist with toileting and was frequent incontinent of bowel without a toileting program. R44's care plan revised on 10/22/19, indicated R44 had an ADL self-care performance deficit and directed staff to provide extensive assistance of staff for the use of the bed pan for bowel movements. R44 was interviewed on 11/8/19, at 8:15 a.m. and stated staff when staff would call in he would wait a long time for assistance from staff after activating his call light. NA-A was interviewed on 11/8/19, at 8:20 a.m. and confirmed R44 was waiting at least 30 minutes on the bedpan. NA-A stated they were "really far behind" getting residents up for the day. The director of nursing (DON) was interviewed on 11/8/19, at 1:06 p.m. and stated she expected staff to respond as promptly as they were able. The facility policy regarding toileting was requested, but not provided. 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	2 920		

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2 920	Continued From page 102 required supervision and/or oversight with ADLs. 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 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 report indicated bathing "Not Applicable;"	2 920		

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2 920	Continued From page 103 -On 9/29/19, the report indicated bathing "Not Applicable;" -On 10/13/19, the report indicated bathing "Not Applicable;" -On 10/27/19, the report indicated independent with bathing; -On 10/31/19, the report indicated bathing "Not Applicable;" -On 11/7/19, (after survey began), the report indicated extensive assist with bathing. R43 was interviewed on 11/6/19, at 8:32 a.m. and stated he "wants a shower." R43 was observed to have approximately quarter inch long finger nails with brown dirt underneath the nail, dirty clothing with food stains on them, and R43 was malodorous. R43 stated he had not had a shower in over two weeks and when he had requested no staff would come back to assist him. NA-B was interviewed on 11/5/19, at 2:32 p.m. and verified R43 had not had a shower for three weeks. NA-C was interviewed on 11/6/19, at 8:41 a.m. and confirmed R43 had not had a shower lately. NA-C explained at times residents would miss their scheduled shower and the shower would be moved to the next day and/ or the next day. NA-C stated showers were documented in the electronic medical record when completed. DON was interviewed on 11/8/19, at 12:07 p.m. and stated it was her expectation for R43 to be showered per the shower schedule which was weekly. DON stated she expected a male staff to shower R43 per request and confirmed R43 had not been showered in the past two weeks. However, DON stated R43 did receive a shower last evening.	2 920		

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2 920	Continued From page 104 A facility policy regarding bathing was requested, but not provided. R29's 8/29/19, quarterly MDS identified R29 had severe cognitive impairment. R29 required extensive assistance of one staff to dress and perform personal hygiene. R29's diagnoses included Alzheimer's disease, dementia with behaviors, weakness, degenerative joint disease, dystonia (uncontrolled movement), and history of dehydration. R29's care plan identified R29 had dementia with cognitive loss, limited physical mobility, and weakness. R29 was unable to provide self-care. He required extensive assistance of 1 staff to dress and perform personal hygiene. R29 was unable to communicate needs. Staff were to anticipate and meet R29's needs. R29 had aggressive behavior with cares. R29 had a recent diagnosis of dehydration. Staff were to supervise and assist R29 with meals, encourage fluid intake, and provide a nosey cup for fluid intake. R2 was at risk for aspiration and had problems coughing and choking while eating and drinking. R29 was not to use straws. R29's undated, current NA care sheet included R29 required extensive assistance of two staff to perform personal hygiene. R29 was to eat only with supervision. R29 ate in the small dining room to ensure staff could observe him at all times during meals. Staff were to offer fluids throughout the day and use a nosey cup for liquids. Observation on 11/4/19, of R29 at 10:37 a.m.	2 920		

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2 920	Continued From page 105 identified R29 appeared unshaven, and debris under his fingernails. 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. Interview on 11/7/19, at 1:15 p.m. with LPN-E stated he was unaware R29 was not supposed to drink with a straw. LPN-E acknowledged he had not looked at R29's care plan prior to providing R29 a straw to drink the supplement. LPN-E checked R20's electronic medication administration and verified it did not indicated R29 was not to drink with a straw. Interview on 11/07/19, at 2:54 p.m. with DON identified she was aware of R29's unkempt unshaven face. Staff reported they attempted to shave him but his razor blades were dull. Two	2 920		

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2 920	Continued From page 106 weeks ago, DON contacted R29's guardian to purchase new razor blades. R29's guardian was new, and unable to access R29's money to purchase new blades until recently. The facility had no razor blades for R29 to use in the meantime. DON stated staff were to use nosey cups for R29 and provide supervision with meals and fluid intake. The care plan stated no straws. DON expected staff to follow R29's care plan. Interview on 11/08/19, at 11:49 a.m. speech therapist (ST)-A verified R29 required assistance and supervision to eat and drink. ST-A instructed staff to not use straws because R29 was not swallowing well following a recent change in condition and was at risk for silent aspiration where fluids had the potential to enter his airway and lungs. The only way to diagnose silent aspiration was by performing a video swallow study. R29 was to undergo testing, however that had been canceled due to R29's admission to hospice. ST-A was unable to verify if straw use was appropriate without a video swallow study. As a precaution, had not recommended R29 to use a straw. R42's 9/30/19, quarterly MDS identified his cognition was intact. R42 had minimal signs of depression, but felt tired and had little energy several days per week. R42 had hallucinations and no behaviors. R42's functional status needs included extensive assistance of 2 staff to transfer. R42 required extensive assistance of 1 staff for bed mobility, locomotion on and off the unit, and with personal hygiene. An observation and interview with R42 on 11/04/19, at 3:41 p.m. identified R42 was lying in	2 920		

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

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2 920	Continued From page 107	2 920		

bed. R42's bed was at floor level. R42's bed and clothing had crumbs on it. He was wearing oxygen. R42's facial hair was ½ inch long, and covered his face. R42 was not growing a beard and was unable to shave because the electric razor he had recently purchased was missing. R42 was "fed up with how they do things around here because they [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 asking for it. R42 required assistance to shave, bathe, use the bathroom and perform daily care. R42 also required assistance with ambulation in his wheelchair as he tired easily. On several occasions R42 asked for assistance to get back to his room. Staff told R42 could push himself and frequently refused to help him back to his room. R42 frequently waited for over one-half hour for assistance when he activated his call light to get help.

Observations from 11/04/19, at 6:41 p.m. through 11/07/19, at 7:41 a.m. identified R42 continued to be unshaven.

Observation and interview on 11/07/19, at 12:42 p.m. NA-C stated staff periodically check R42's liquid oxygen canister to make sure it was on. She was unsure if he needed oxygen at all times, but usually saw him wearing it. NA-C had not assisted R42 to his room after lunch, and was unsure if any other staff assisted him to his room. R42 was able to pedal himself in the hallways from the dining room, and was unsure if he required help to get to and from the dining room.

Interview on 11/07/19, at 2:44 p.m. with DON identified she had asked staff to shave R42 for the past 2 days. DON was aware R42 reported

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2 920	Continued From page 108 his razor was missing, but did not complete a grievance because he was a hoarder, and his razor was not missing. DON stated was not sure what was wrong with R42, because he was never like this. DON verified she had requested staff to assist R42 to shave on Tuesday, and she would have staff find his razor and assist him to shave today. At 3:20 p.m. DON reported staff found his new razor in his bucket in his room on the night stand. DON verified staff had not looked for the razor and had not shaven R42 after she requested them to, but they were assisting him now. A policy and procedure was requested for quality of care or providing activities of daily living. No policy was provided. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could review and /or revise policies and procedures to ensure all residents received assistance with toileting cares and bathing. DON or designee could develop monitoring systems to track compliance and report results to the Quality Assurance and Performance Improvement (QAPI) committee. QAPI could conduct audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement	21385		12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21385	Continued From page 109 the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide safe handling of catheter bag and tubing in accordance with infection control standards of practice for 1 of 1 resident (R20). In addition, the facility failed to ensure proper handwashing and glove usage for R20 during observation of care for a suprapubic catheter (a catheter placed below the navel into the bladder to drain urine). Findings Include: R20 was observed on 11/5/19, at 8:09 a.m. and his urinary catheter tubing was dragging on the floor. The urine drainage bag was uncovered and hooked under the wheelchair as resident propelled himself around the dining room area to the television area, back and forth. The emptying spout was out of the holder although it was clamped and observed dragging on the floor. R20 was observed again on 11/06/19, at 10:36 a.m. the drainage bag was covered with a privacy bag, however the bag and the tubing were dragging on the floor. Review of admission Minimum Data Set (MDS) assessment dated 8/14/19, indicated R20 had diagnoses that included Alzheimer's disease and dementia; had an indwelling catheter and required extensive assistance with toilet use, bed mobility and transfers. R20's admission record dated 8/7/19 indicated	21385	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21385	Continued From page 110	21385		

R20 had diagnoses of retention of urine and history of malignant neoplasm of the prostate. Review of care plan dated 8/13/19, revealed R20 had suprapubic catheter. Physician order dated 9/3/19, indicated R20 had permanent suprapubic catheter, cleanse site with normal saline, pat dry, apply split gauze to secure two times a day for catheter cares.

Licensed Practical Nurse (LPN)-E was observed providing care and treatment for R20 on 11/7/19, at 9:41 a.m. LPN-E donned gloves and used ProCare wipes to clean R20's bottom after R20 had a small bowel movement. LPN-E removed gloves and sanitized hands with foam hand sanitizer. LPN-E then proceeded to change the dressing on the suprapubic catheter site. LPN-E took off the old dressing with noted drainage to the dressing. LPN-E without changing gloves or performing hand hygiene took ProCare wet wipes and cleansed the catheter site with the wipes. After cleaning site with the wet wipes LPN-E then applied a new gauze and taped it in place. After all cares were completed LPN-E washed his hands at the sink.

Nurse Manager, Registered Nurse (RN)-A was interviewed on 11/07/19, at 8:55 a.m. RN-A stated R20 was on hospice and orders were to complete suprapubic site care twice a day. The expectations was the catheter tubing should not be dragging on the floor and the urine drainage bag should be kept in a privacy bag. RN-A also verified the ProCare wet wipes were to be used for incontinent cares only.

LPN-E was interviewed on 11/8/19, at 10:17 a.m. LPN-E stated the current order for suprapubic site care was to clean with normal saline and apply gauze. LPN-E also verified that he did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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

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21385	Continued From page 111 use normal saline and instead used the ProCare wet wipes during suprapubic site care. Assistant Director of Nursing, Registered Nurse (RN)-B, was interviewed on 11/08/19, at 12:04 p.m. RN-B verified she was also the Infection Control Nurse. RN-B stated it was the expectation staff changed gloves and washed hands after cleaning up after a bowel movement and before providing care for the suprapubic dressing change. RN-B explained Infection control education was usually done with facility staff, however, agency pool staff were assumed to have infection control competencies prior to providing care in the facility. RN-B further stated the facility did not have a system for training pool staff on infection control. Review of undated facility policy entitled Infection Control Guidelines for all Nursing Procedures, indicates Standard Precautions will be used in the care of all residents. Standard precautions apply to blood, body fluids, secretions and excretions. Employees must wash hands for 10 to 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after contact with blood, body fluids, secretions, mucous membranes or non-intact skin; after handling items potentially contaminated with blood, body fluids or secretions; after removing gloves. Suggested Method of Correction: The DON (Director of Nursing) or designee could audit catheter bag placement and monitor handwashing during cares and treatments. In addition, DON or designee could educate staff and perform audits to ensure the policies are being followed.	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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

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21385	Continued From page 112 Time Period for Correction: Twenty-one (21) days.	21385		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure baseline tuberculosis (TB) screening components were completed for 1 of 5 newly admitted residents (R44) and 1 of 5 residents (R25) received the second step tuberculin skin test (TST) within the required timeframe. The facility also failed to ensure two-step TST was completed and results	21426	Corrected	12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 113	21426		

accurately documented for 2 of 6 employees (E1, E4) per current Center for Disease Control and Prevention (CDC) recommendations and facility policy. This had the potential to affect all residents residing in the facility and employed staff.

Findings include:

R25 was admitted to the facility on 9/4/19. R25 received the first TST and had it read on 9/6/19, and then had the second two-step TST administered on 9/10/19, only four days after first TST was read. During interview on 11/8/19, at 1:00 p.m. with the assistant director of nursing (ADON) indicated the second TST was given too early and agreed it should have been given at least a week after first one was read.

R44 was admitted to the facility on 1/16/19. Although R44 received the two-step TST, no assessment for current symptoms, risk factors or TB history had been completed. During interview on 11/8/19, at 1:05 p.m. ADON indicated she was unable to find the symptom screen and verified R44's medical record lacked verification of completion.

E1 had a hire date of 10/8/19, and had the first-step TST on 10/3/19, that was not read. E1 then received a new first-step TST on 10/8/19, with no second-step TST being completed.

E4 had a hire date of 6/12/19, and had first-step TST read on 6/11/19, but had no date identified when it was given. E4 had second-step read on 6/26/19, with negative results.

During interview on 11/8/19, at 1:10 p.m. ADON indicated that E4's first TST should not be used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 114	21426		

as there was no identified date of administration. ADON verified that E1 had not had second-step TST and will be completed today. ADON stated that the facility was working with medical director on switching over to Tuberculosis (TB) Gold blood draw type of testing as the facility had problems with staff getting their TST read.

The facilities TB risk assessment worksheet dated 11/12/18, included: baseline TB screening was required at the time of hire for all healthcare workers in Minnesota. Baseline TB screening includes: (1) assessing for current symptoms of active TB disease, (2) assessing TB history, and (3) testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test.

Review of undated, Tuberculosis, Screening Residents for policy, identified all resident shall be screened for tuberculosis infection and disease for admission or readmission.

Review of undated, Tuberculosis, Employee Screening for policy identifies that newly hired employees will receive a two-step TST to ensure no active TB symptoms.

SUGGESTED METHOD OF CORRECTION: DON or designee could monitor for compliance of the tuberculosis screening process for all residents and employees to ensure the TST and baseline TB screenings are being completed according to CDC recommendations. The administrator or designee could update their current policies related to tuberculin testing and TB screening for staff and residents and educate responsible staff related to the changes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 115 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide person centered, meaningful activities which included activities outside of the facility for 1 of 3 residents (R43) reviewed for activities. Findings include: R43 was interviewed on 11/4/19, at 6:55 p.m. and stated he was unable to attend the monthly shopping activity due to the facility scheduling the outings outside of the facility on Wednesdays which conflicted with R43's dialysis schedule. R43 indicated it was important for him to go person item shopping for himself due to having been a younger man and not wanting staff and/or	21435	Corrected	12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 116	21435		

his mother always doing his personal item shopping. R43 stated he spoke to the director of nursing (DON) and the activities director (AD) about his desire to participate in a shopping activity, however no changes and/ or follow-up occurred.

R43's annual Minimum Data Set (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 it was "very important" for R43 to do his favorite activities.

R43's care plan revised on 10/23/19, identified R43 had little time in the facility to participate in activities and directed staff to explain to R43 the importance of social interaction, leisure activity time, participation in activities, invite/ encourage R43's family to attend activities with R43 to support participation, offer a variety of activity types and locations to maintain interests, modify daily schedule and treatment plan to accommodate activity participation as requested by R43.

R43's Activity Participation Review effective 10/2/19, indicated R43's attendance preferences and participation level with activities was left blank, no interventions and/ or adaptations needed for R43 to participate in programs, care plan remained current and appropriate, goals were met and interventions remained effective.

R43's Activity Schedule was reviewed from 8/2019, through 10/31/19, and revealed the following:
-R43's 8/2019, schedule indicated R43 participated in going outdoors, watching TV and/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 117	21435		

or movies and physical games/ activity daily, however lacked evidence of facility outing;
-R43's 9/2019, schedule indicated R43 participated in one facility outing on 9/19/19, and daily going outdoors and physical games/ activity;
-R43's 10/2019, schedule indicated R43 participated in going outdoors daily and physical games/ activity, however lacked evidence of facility outing, however lacked evidence of facility outing.

AD was interviewed on 11/8/19, at 10:03 a.m. and verified R43 had not participated in an activity outside of the facility since 9/2019, when he went for a senior golf cart ride and in 7/2019, when he attended a baseball game. AD stated R43 enjoyed going outside daily to smoke on the front patio and visit with peers. AD confirmed the facility offered shopping activities on Wednesdays, however R43 was unable to attend due to R43's dialysis schedule. AD stated she was aware R43 "mentioned" he wanted to out of the facility shopping and/ or to activities outside of the facility, however AD stated Wednesdays worked best for the activities department due to their staffing. AD explained she had not attempted to offer an alternate day for activities outside of the facility, however identified Thursdays staffing would be able to accommodate this.

DON was interviewed on 11/8/19, at 12:11 p.m. and stated it was her expectation for the facility to try their best to make accommodations so all residents were able to participate in activities. DON explained R43 was able to attend an activity outside of the facility over the summer, however R43's dialysis had to be rearranged to ensure R43 could attend.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 118 The facility activity policy was requested, but not provided. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure all residents received a comprehensive activity assessment to assist with developing individualized, resident centered interventions. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate	21525	Corrected	12/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 119 narcotic documentation for 6 of 7 (R23, R25, R26, R36, R45, R51) residents. Additionally, the facility failed to ensure a minimum of daily reconciliation of narcotic counts on two days during October and November, 2019. In addition, the facility failed to ensure narcotics were reconciled and destruction was monitored and documentation maintained for 1 of 1 resident (R32) reviewed for medication administration. 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. R23's medication administration record (MAR) indicated R23 was prescribed hydrocodone-acetaminophen 5-325 milligrams (mgs) every six hours for pain. On 10/23/19, R23 had three doses of oxycodone signed out by nursing staff in the narcotic sign-out book for R23, however four doses were documented in R23's MAR. On 10/24/19, five doses were signed out with the fifth (last) dose dated 10/24/19, identified as being the 2:00 a.m. dose. The next three doses signed out in the narcotic log were dated 10/25/19, for the usually scheduled doses for 7:00 a.m., 1:00 p.m., and 7:00 p.m. It appeared the fifth dose signed out on 10/24/19, was dated incorrectly and was actually the 2:00 a.m. dose for 10/25/19. These discrepancies were verified by licensed practical nurse (LPN)-D during an interview on 11/8/19, at 10:12 a.m. and by the director of nursing (DON) on 11/8/19.	21525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 120	21525		

R25
R25's MDS dated 9/11/19, identified diagnoses that included fractures in left foot, end stage liver disease, cirrhosis, and ascites. It indicated R25 was cognitively intact.

R25's MAR indicated R25 was prescribed 5 mg of oxycodone every six hours for pain.

On 10/29/19, one dose of oxycodone was signed out in the narcotic sign-out book, however, two doses were documented in R25's MAR. This discrepancy was verified by LPN-E during an interview on 11/12/19.

R26
R26 resided on a secured memory unit with diagnoses including arthritis of the knee, low back pain, and unspecified pain, according to admission record dated 7/10/18.

Per physician orders dated 11/12/19, R26 was to receive the medication oxycodone (a narcotic pain medication) five mgs four times per day for pain.

On 11/12/19, at 09:19 a.m. the required narcotic administration tracking book for R26 was reviewed with Trained Medication Aide (TMA)-A. A discrepancy appeared to exist when it was noted administered scheduled medications had not been registered in the narcotic sign-out book. On further investigation, R26 had 2 separate cards of pills and 2 separate pages for documentation, one page for each card of pills.

R36
R36's provider order summary printed 11/12/19, indicated diagnoses included chronic pain syndrome, persistent fracture of left humerus,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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

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21525	Continued From page 121	21525		

several pressure ulcers, and quadriplegia. The summary indicated R36 was prescribed oxycodone 15 mg every four hours for chronic pain.

On 10/16/19, two doses of oxycodone were entered into the narcotic sign-out book, but four doses were documented as given in R36's MAR with two doses were blank. On 10/17/19, the 4:00 p.m. and 10:00 p.m. doses were signed out, but there were three doses documented at 4:00 p.m., 6:00 p.m., and 10:00 p.m.. There were three doses left blank. On 10/19/19, four doses were signed out and all six scheduled doses were documented in the MAR.

During an interview on 11/12/19, at 9:45 a.m. LPN-E verified all these discrepancies in both records.

R45
R45's MAR indicated R45 was prescribed oxycodone five mgs three times per day. On 11/1/19, 11/5/19, 11/6/19, and 11/7/19, R45 had oxycodone five mg doses signed out of the narcotic log two times each day. However, three doses were documented in R45's MAR for each of those days. The director of nursing (DON) verified these discrepancies during an interview on 11/8/19, at 9:24 a.m..

R51
R51's MAR indicated R51 was prescribed hydromorphone one mg every four hours for chronic respiratory failure with hypoxia. On 10/14/19, and 10/15/19, four doses were signed out in the narcotic sign-out book, but six doses were documented in R51's MAR. On 10/16/19, and 10/17/19, five doses were signed out and six doses were entered in the MAR. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21525	Continued From page 122 verified these discrepancies during an interview on 11/8/19, at 9:24 a.m.. The three current narcotic reconciliation logs were reviewed on 11/6/19, at 1:05 p.m. to verify accurate practice for reconciling the narcotic counts. It was noted that there were more than 100 missing signatures on shifts with no signatures. The narcotic log for station 300 showed from 10:00 p.m. on 9/27/19, to 2:00 p.m. on 9/28/19, totaling 40 hours, there were no signatures for 40 hours. Additionally, from 6:00 a.m. on 10/18/19, to 10:00 p.m. on 10/9/19, there were no signatures indicating narcotic medication reconciliation was completed. DON verified these missing signatures on the narcotic count on 11/8/19, at 9:45 a.m. and indicated it was the expectation that they should be counted at the end of every shift. The administrator was interviewed on 11/12/19, at 12:40 p.m. and confirmed there were no formal audits of narcotic use and or documentation. The consultant pharmacist (CP) was interviewed on 11/12/19, at 2:55 p.m. and stated he was aware of the narcotic diversion but did not know any specifics. CP indicated that he attended the quarterly quality council meeting once each quarterly and is scheduled for next week. CP stated narcotics were refilled on demand, but were required to have a provider order and that only two months could be ordered at a time. Typically, only one month or less of narcotic prescription was sent at a time. The pharmacist indicated that there was a 10% audit process included in the pharmacy services, but the facility could contract for a more robust service.	21525		

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	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

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21525	Continued From page 123 The facility's Controlled Substances policy revised 8/2/19, indicated that nursing staff "must count controlled medications at the end of each shift". A nurse going off the shift and a nurse coming on duty must make the count together and document and report any discrepancies to the DON. R32's annual MDS dated 9/19/19, indicated R32 had intact cognition and diagnoses which included anxiety, asthma, chronic obstructive pulmonary disease or chronic lung disease. The annual MDS indicated R32 had frequent pain and received opioid seven out of seven days. R32's Order Summary Report dated 11/12/19, included morphine sulfate solution every one hour as needed for pain and/or shortness of breath. R32's Individual Narcotic Record was reviewed 5/1/19, through 11/12/19, and revealed the following: -R32's morphine sulfate (narcotic schedule II controlled substance) dated 5/17/19, at 12:42 p.m. indicated 8.00 milliliters (ml) remained, however R32's medical record lacked evidence regarding further account for the 8.00 ml of morphine sulfate; -R32's morphine sulfate dated 10/26/19, at 5:51 p.m. indicated 5.75 ml remained; -R32's morphine sulfate dated 10/31/19, no time noted indicated "remeasured" 1.00 ml remained, however R32's medical record lacked evidence regarding account for the 4.75 ml from 10/26/19, to 10/31/19, and further lacked evidence of the account of the remaining 1.00 ml.. R32 was interviewed on 11/12/19, at 9:16 a.m. and stated his pain was "good" and denied	21525		

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21525	Continued From page 124 shortness of breath. R32 was observed on 11/12/19, at 9:16 a.m. calm and no signs of pain and/or shortness of breath. LPN-D was interviewed on 11/12/19, at 10:16 a.m. and verified she was unable to locate R32's morphine sulfate dated 5/17/19, with 8.00 ml and 10/31/19, with 1.00 ml remaining. LPN-D stated she was unsure what happened from 10/26/19, to 10/31/19, regarding R32's 4.75 ml of morphine sulfate. 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. The consultant pharmacist was interviewed via telephone on 11/12/19, at 2:57 p.m. and stated per the board of pharmacy it was expected for two individuals at the facility destroy narcotics together and a "paper trail" should have been kept for a minimum of two years. The facility Controlled Substances policy updated 8/2/19, indicated the facility would comply with all laws, regulations and other requirements related to handling, storage, disposal and documentation of schedule II and other controlled substances. The policy indicated nursing staff must count controlled medications at the end of each shift, the nurse coming on duty and the nurse going off	21525		

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21525	Continued From page 125 duty must make the count together. DON would investigate any discrepancies in narcotic reconciliation to determine the cause and consult the pharmacy and administrator to determine any needed legal action. The facility Discarding and Destroying Medications policy adopted 8/12/19, indicated medications would be disposed in accordance with federal and state regulations. The policy indicated all unused controlled substances would be retained in a securely locked area with restricted access until disposed of. The policy indicated disposal of controlled substances must have taken place immediately no longer than three days after discontinued. Following medication destruction a disposition record would include reason for disposition, method and witness signature. The medication disposition record would have been kept on file for two years. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee and consultant pharmacist could review policies and procedures related to medication reconciliation to ensure policies address system for timely identification of loss or diversion of narcotic medications. Facility staff could be educated on facility policies and procedures. The DON and/or designee could audit medication reconciliation to ensure staff compliance. The DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21525		

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21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the	21830		12/29/19

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21830	Continued From page 127	21830		

resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social

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21830	Continued From page 128 service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient'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. 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 (-). 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. 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	21830	Corrected	

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21830	Continued From page 129	21830		

needed. RN-A (who is 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 still on.
- At 6:23 p.m. DON said to unidentified nursing assistant (NA), "Whose call light is on?" NA told 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 his program Chicago PD was coming on television.
- At 6:29 p.m. R46's call light over his door went off, DON was 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

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21830	Continued From page 130	21830		

at nurse station yelling, "Help! Help!"
- At 6:30 p.m. DON entered an unidentified room number which had call light on above door and exited room with call light still activated.
- At 6:31 p.m. R46 was observed sitting in his w/c in his room waiting for assistance to bed with call light on.
- At 6:33 p.m. there were no call lights activated in hall 200
- At 6:33 p.m. R46 was observed still waiting in his room to go to bed.
- At 6:38 p.m. R10 and R54's call lights came on over their room doors.
- At 6:40 p.m. R46 wheeled himself out of his room into hallway looking down hallway. RN-A told R46 she could get R46 hooked up to the lift while he was waiting.
- At 6:44 p.m. R46 was observed sitting in his w/c in his room with RN-A present hooked up to the transfer lift.
- At 6:47 p.m. NA walked into R46's room to assist RN-A to transfer R46 to bed. (R46 waited 41 minutes for staff assistance).

During interview on 11/4/19, at 7:18 p.m. R46 stated he wanted to go to bed at 6:00 p.m. every evening and he usually "waited that long all the time to go to bed, it's the usual."

RN-A nurse manager, stated on 11/7/19, at 2:26 p.m. R46 could go to bed at 6:00 p.m. and all staff knew that. RN-A stated R46's preferred bedtime was not identified on R46's NA care sheet and "Staff just know by word of mouth."

R46's careplan dated 11/7/19, did not include R46's preference for bedtime at 6:00 p.m..

DON stated on 11/7/19, at 2:45 p.m. that R46 could go to bed at 6:00 p.m. as it was his

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21830	Continued From page 131 preference. DON stated staff should accommodate this and follow residents' careplan. Facility policy Self Determination and Participation dated 7/25/16, indicated residents would be allowed to choose schedules that are consistent with their interest for daily routine including sleeping. The policy indicated to facilitate resident choices staff would gather information about residents' personal preferences upon initial assessment and periodically thereafter, and document these preferences in the medical record. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff regarding residents' preferences with plan of care. DON or designee could develop and implement policy and procedure regarding resident preference with plan of care. Audits of care plans could be done routinely to ensure residents' preferences were honored. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21830		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when	21840		12/29/19

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21840	Continued From page 132 legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an accurate record was updated to include appropriate code status (a resident's wishes for life-saving emergency treatment) regarding cardio pulmonary resuscitation (CPR) for 1 of 12 residents (R42) reviewed for Advance Directives. Findings include: R42's EMR (electronic medical record) was accessed on 11/04/19. R42's EMR identified he was full-code status (indication to initiate CPR). R42's physician orders dated 10/31/19, identified R42 had full code status. R42's 5/23/19, Physician Order for Life Sustaining Treatment (POLST) identified R42's code status was DNR/DNI (do not resuscitate/do not intubate). The POLST form was signed by registered nurse (RN)-A and R42's physician, and was the most recent POLST in R42's EMR. R42's signature was not written on the document. Interview on 11/5/19, at 1:42 p.m. with licensed practical nurse (LPN)-D identified R42's EMR indicated R42 had full code status. LPN-D stated if R42 arrested, the quickest way to identify code status was to look in R42's EMR. If the code status was not identified in R42's EMR, LPN-D stated she used the most recent POLST in the	21840	Corrected	

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21840	Continued From page 133 EMR scanned documents. During interview on 11/5/19, at 1:54 p.m. R42 stated he wanted to be resuscitated if he stops breathing and his heart stops. R54's EMR was reviewed again on 11/5/19. The EMR identified R42's code was DNR/DNI. During interview on 11/5/19, at 4:10 p.m. with RN-A verified she was unsure why R42 had a POLST indicating he was DNR/DNI in the chart, and agreed it could cause R42 to receive the incorrect resuscitation measures if he had cardiopulmonary arrest. The director of nursing (DON) was interviewed on 11/5/19, at 4:14 p.m. and stated she expected the staff to follow the POLST to ensure appropriate resuscitative measures were implemented according to resident and family choices. DON verified R42 continued to choose to maintain full-code status. DON confirmed she had just changed R42's code status to DNR in his electronic medical record after reviewing his 5/23/19, POLST. R42 was his own responsible party and was re-interviewed, and chose to remain full code, so his code status was going to be changed back to full-code in the EMR. DON agreed staff had the potential to deliver the incorrect resuscitative measures with conflicting POLST and EMR documentation. During interview on 11/5/19, at 4:21 p.m. RN-B stated she was the staff development (SD) coordinator, and was responsible for staff training and orientation. She instructed new licensed staff about the crash cart and where to identify code status. SD stated she expected staff to use the most recent POLST rather than information from	21840		

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

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21840	Continued From page 134	21840		

the EMR because the POLST was the most accurate and current document identifying a resident's code status. She had worked in her role for about a year, and was unsure how or who was responsible for educating existing licensed staff about the facility's crash cart, and the facility's code status policies and procedures. RN-B was not familiar with the facility's code status policies and procedures, which were not reviewed with staff on a routine basis. Additionally, RN-B verified she had no documentation code status education was provided for new facility and agency staff upon hire.

On 11/5/19, at 4:28 p.m. the social worker (SW) -A indicated residents were encouraged to complete advanced directives upon admission. A POLST was provided and reviewed with new residents to establish code status and health care directives upon admission. Code status was reviewed quarterly, and on an as-needed basis, with significant changes in status, and after hospitalization. The nurse managers (NM) were responsible for updating and ensuring accuracy of each resident's code status. NM were also responsible to ensure the resident and/or guardian decisions were documented with all necessary signatures, included on the POLST, updated and accurate in the residents EMR, care plan and physician orders. SW-A was unsure of any additional processes in place to ensure 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

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	00758	A. BUILDING: _____ B. WING _____	C 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

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21840	Continued From page 135	21840		

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 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. If a resident had questions, staff referred a resident to the resident's family, physician, and outside resources. The policy did not direct staff to a specific document in the event of code status discrepancies, and did not identify a process to ensure accuracy of resident code status.

The Emergency Procedure-Cardiopulmonary Resuscitation policy and procedure dated 8/3/16, indicated the procedure for administering CPR incorporated the steps in the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency

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21840	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.	21840		
21870	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, R18, R22, R24, R37) in Resident Council.	21870	Corrected	12/29/19

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21870	Continued From page 137 Findings include: During resident council meeting on 11/6/19, at 2:08 p.m. R1, R3, R12, R51, R18, R24, R37 stated they waited a long time for their call lights to be answered, up to an hour and longer they waited for staff assistance. R1, R3, R12, R51, R18, R24, R37 stated long call lights had been a problem in the facility since last spring, and was getting worse the last couple of months, and stated nothing had been changed or done to help with the problem. Resident Council (RC) minutes dated 4/24/19, identified residents present at the April meeting expressed call lights were not answered in a timely manner. RC members stated nursing assistants (NA)s turned off the call lights and ignored residents who activated their call lights. April 2019 Grievance reports identified no report was completed for resident council complaints regarding call light concerns. RC minutes dated 5/29/19, identified long call lights not being answered at meals and still being turned off with no assistance provided. A letter dated 5/7/19, responding to RC members did not address concerns with call lights. RC minutes dated 6/26/19, identified call lights not being answered in a timely manner waiting 45 minutes to 1 hour for staff assistance, and staff still turning off call lights without talking to the resident and providing assistance. RC minutes dated 7/31/19, identified residents were frustrated over no resolution to the same call light concerns and nothing being done about	21870		

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21870	Continued From page 138 them. RC minutes dated 8/28/19, did not note anything regarding call lights or staffing. RC minutes dated 9/25/19, did not note anything regarding call lights or staffing. RC minutes dated 10/10/19, identified there had been no follow up done for long call light wait times and staff behaviors. 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. During interview with administrator on 11/12/19, at 2:28 p.m. he stated he did not read the monthly RC minutes and stated each department head was responsible for follow up with concerns from residents at the monthly meetings. Administrator stated no call light audits had been completed regarding residents' concerns with long call light wait time 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. Grievance policy dated 10/10/19, indicated the facility encouraged all residents to utilize the Resident Council as an opportunity to meet with	21870		

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21870	Continued From page 139 other residents to discuss any area of concern. The policy indicated residents' concerns would be addressed in a satisfactory and timely manner. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise facility systems, to ensure voiced concerns in the resident council were addressed in a timely manner. The administrator or designee could educate all appropriate staff. The quality assurance (QAA) team could develop auditing systems to ensure ongoing compliance and report those results to the quality assurance team for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every	21880		12/29/19

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21880	Continued From page 140 residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow up on a report of a missing ring for 1 of 2 residents (R25) reviewed for missing personal property. Findings include: R254's Minimum Data Set (MDS) dated 9/30/19, indicated R254 was admitted on 9/26/19, from the hospital with diagnoses that included alcoholic hepatitis and withdrawal, depression, and muscle weakness after falling at home and hitting his head. The MDS indicated R254 was cognitively	21880	Corrected	

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21880	Continued From page 141 intact. R254 was interviewed on 11/4/19, at 1:54 p.m. and stated he was there for physical therapy to increase strength with a plan to discharge to home. During an interview on 11/4/19, at 4:30 p.m. R254 indicated he was missing a ring from the top drawer of the nightstand next to the bed. R254 stated the ring had been in a sandwich-sized plastic baggie and noticed it was missing in mid October. R254 described the ring as gold with an amethyst center stone missing. R254 stated the ring had been his father's wedding ring from 1945 and the stone was both his father's and his birthstone. R254 estimated the cost of the ring to be $200. R254 indicated the ring was mostly of sentimental value. R254 stated the missing ring was reported to the Director of Social Services (DSS) when he noticed it was missing but was told there was nothing that could be done. R254 also stated he did not know if it was stolen. DSS was interviewed on 11/7/19, at 2:24 p.m. and verified R254 reported the missing ring to her but stated there was no investigation initiated because the ring was not included in R254's personal property inventory completed on admission. DSS indicated she was not able to retrieve the inventory in R254's medical record, but thought it just hadn't been scanned in. DSS requested a copy from medical records. Staff were told to keep their eyes open for it. Additionally, she confirmed she was not aware of the value or if R254 thought it was stolen. LPN-G and LPN- H were interviewed on 11/7/19, at 2:32 p.m. and neither were not aware of a missing ring.	21880		

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21880	Continued From page 142 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	21880		

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21880	Continued From page 143 made for any item valued at $50 or greater. R254 was confused when admitted and the administrator indicated the family should have been contacted to verify the item was missing. The administrator also stated he was confident no one had seen the ring and the facility did not usually contact hospitals to see if the item was sent with the resident. The administrator indicated DSS should have taken a few more steps. DSS was interviewed again on 11/12/19, at 10:26 a.m. and verified the the family had not been contacted. The DSS was not able to produce the personal property inventory. The facility Grievance Policy dated 10/10/2019, outlined that missing article grievances are directed to the DSS and the follow up process included investigation of specific details surrounding the issue of concern, with the goal of addressing and resolving the concerns. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents and staff are aware of grievance process and follow through. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults	21995		12/29/19

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21995	Continued From page 144 Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to report timely an allegation of mistreatment to the State Agency (SA) for 1 of 5 residents (R41) reviewed for 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 like ...was 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 reported to the SA. DON indicated LPN-A and/or R41 or other staff were not interviewed at that time. DON, the assistant director of nursing (ADON) and NA-B were interviewed on 11/5/19, at 5:06 p.m. and NA-B stated on 11/2/19, it was reported to ADON that a few evenings ago NA-B observed LPN-A "being physical" and "rough" with R41.	21995	Corrected	

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21995	Continued From page 145	21995		

NA-B explained R41 was asking not to be touched and LPN-A continued on and "man handled" R41 as R41 was "begging not to touch" her. NA-B stated R41 repeatedly yelled, "leave me alone leave me alone" as R41 tightened her arms inward, however LPN-A did not stop. NA-B indicated LPN-A asked NA-D to assist with changing R41 out of urine soaked clothing and both LPN-A and NA-D continued "manhandling" R41 while "pulling her clothes off against her will." ADON confirmed that 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 it was not reportable. NA-B stated he did not report the concern of rough treatment to R41 right away due to having been a newer staff at the facility and worried about retaliation from LPN-A.

DON was interviewed on 11/6/19, at 10:35 a.m. and verified a report regarding an allegation of physical abuse was submitted to the SA on 11/5/19. DON stated it was their expectation to report any allegation of abuse to the administrator and/or SA within two hours.

R41 was interviewed on 11/7/19, at 6:49 a.m. and was unable to answer questions.

R41's Quarterly Minimum Data Set (MDS) dated 8/26/19, identified R41 had severe cognitive impairment and diagnoses which included dementia and Parkinson's disease. The Quarterly MDS indicated R41 required extensive staff assistance with activities of daily living.

The facility Abuse Policy and Procedure adopted 9/27/19, indicated abuse referred to mistreatment or infliction of harm by someone to an individual. The policy indicated residents had the right to be

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21995	Continued From page 146 free from abuse and the facility would not condone any form of resident abuse. The policy indicated any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the administrator, DON or change nurse and when an incident of resident abuse was suspected or confirmed the incident must have been reported to facility management regardless of the time lapse. The policy further indicated the facility would report suspected or identified abuse in a timely manner to appropriate agencies. SUGGESTED METHOD OF CORRECTION: The administrator could review policies and procedures regarding reporting of all alleged mistreatment. The administrator and or designee, could re-educate all staff on the policies and procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21995		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.	22000		12/29/19

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22000	Continued From page 147 (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview and document	22000	Corrected	

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22000	Continued From page 148 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 like ...was 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. DON, assistant director of nursing (ADON) and NA-B were interviewed on 11/5/19, at 5:06 p.m. NA-B stated on 11/2/19, it was reported to ADON that a few evenings ago NA-B observed LPN-A "being physical" and "rough" with R41. NA-B explained R41 was asking not to be touched and LPN-A continued on and "man handled" R41 as R41 was "begging not to touch" her. NA-B stated R41 repeatedly yelled "leave me alone leave me alone" as R41 tightened her arms inward, however NA-B indicated LPN-A did not stop. NA-B indicated LPN-A asked NA-D to assist with changing R41 out of urine soaked clothing and both LPN-A and NA-D continued "manhandling" R41 while "pulling her clothes off against her will."	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	C 11/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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22000	Continued From page 149 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. DON was interviewed on 11/6/19, at 10:35 a.m. and verified the facility began investigating an allegation of physical abuse and both LPN-A and NA-D were placed on administrative leave. DON stated it was their expectation to begin investigating and observing cares/ monitoring the unit following an allegation of physical abuse. R41 was interviewed on 11/7/19, at 6:49 a.m. and was unable to answer questions. R41's Quarterly Minimum Data Set (MDS) dated 8/26/19, identified R41 had severe cognitive impairment and diagnoses which included dementia and Parkinson's disease. The Quarterly MDS indicated R41 required extensive staff assistance with activities of daily living. The facility Abuse Policy and Procedure adopted 9/27/19, indicated abuse referred to mistreatment or infliction of harm by someone to an individual. The policy indicated residents had the right to be free from abuse and the facility would not condone any form of resident abuse. The policy indicated any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the administrator, DON or change nurse and when an incident of resident abuse was suspected or confirmed the incident must have been reported to facility management regardless of the time lapse. The policy indicates when an incident of suspected resident abuse or mistreatment was reported the facility would initiate a report to the SA and begin investigation of the alleged incident which would include witness reports, staff	22000		

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22000	Continued From page 150 interviews and interview other residents. Furthermore, the policy indicated employees of the facility whom had been accused of resident abuse would be suspended immediately pending outcome of the investigation. SUGGESTED METHOD OF CORRECTION: The administrator could review policies and procedures regarding reporting and investigating all alleged abuse/neglect/mistreatment. The administrator and or designee, could re-educate all staff on the policies and procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	22000		