Electronically delivered
September 8, 2022

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

RE: CCN: 245304
Cycle Start Date: August 11, 2022

Dear Administrator:

On August 24, 2022, we informed you of imposed enforcement remedies.

On August 24, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 8, 2022, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 8, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 8, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of August 24, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 8, 2022. However, due to the extended survey the new NATCEP loss date is August 11, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220

P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 11, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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/ 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 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
September 8, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: HYKP11

Dear Administrator:

The above facility was surveyed on August 23, 2022 through August 24, 2022 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:

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

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/23/22 and 8/24/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H53044233C (MN85692), with a deficiency cited at F609 H53044269C (MN86134), with a deficiency cited at F609 and F656. and The following complaints were found to be unsubstantiated, H53044247C (MN86109) H53044232C (MN86094) H53044290C (MN86167) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		9/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/17/2022

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

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of abuse was reported to the State Agency (SA) for 1 or 2 residents (R4) after R4 was hit by another resident (R2). Findings include:	F 609	1. Staff educated on the importance of reporting incidents within the required timeframe. 2. All residents have the potential to be affected by this type of situation. 3. All IDT will be re-trained and have	

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 R2's quarterly MDS dated 7/27/22, indicated R2 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS) assessment. R2 had diagnoses that included dementia with behavioral disturbance, major depressive disorder, anxiety, Alzheimer's disease, and delusional disorder. R2 required a wheelchair for mobility. R2's progress note dated 7/30/22, indicated R2 hit R4 at 3:00 p.m. while they were side-by-side in the hallway. "The ED [executive director] and DON [director of nursing] were notified." R2's Risk Management form dated 7/30/22, indicated R2 was in the hallway talking to herself when R4 wheeled by her on his way out of the facility to smoke a cigarette. R2 grabbed R4's smoking apron, unfastened the velco, and hit R4 in the chest. R4's quarterly Minimum Data Set (MDS) dated 6/6/22, indicated R4 had no cognitive deficits and used a wheelchair for mobility. R4's diagnoses included schizophrenia, morbid obesity, bipolar disorder, chronic pain syndrome, anxiety, and attention deficit-hyperactivity disorder. R4's progress note dated 7/30/22, indicated R4 was hit in the chest and had his smoking apron partially ripped off by R2 when they passed each other in the hallway. R4's progress note indicated the ED and DON were notified. R4's Risk Management form dated 7/30/22, indicated and R4 was going down the hallway R2 reached out and hit R4 in the chest. R4 stated he was going out to smoke when R2 "off and hit me in the chest".	F 609	access to the OHFC process to be able to submit an incident. 4. The administrator or designee will be informed immediately when an incident has been identified to ensure the incident is reported in a timely manner. IDT will audit daily during IDT morning meeting to ensure sustained correction. Any issues found will be brought to QAPI.	

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 During an interview on 8/23/22, at 12:47 p.m. R4 stated approximately two weeks ago, he was wheeling himself down the hallway when R2 grabbed his smoking apron off of him and hit him. R4 stated he told staff about the incident but could not recall who. During an interview on 8/24/22, at 1:51 p.m. the administrator stated he was sure the staff did Risk Management forms regarding the altercation between R2 and R4 but he could not remember the specifics. The administrator stated he did not believe the incident needed to be reported to the SA because R4 did not sustain any injuries and indicated he felt safe at the facility. The facility Reporting Abuse to Facility Management dated 9/4/20, indicated abuse was the willful infliction of injury or intimidation resulting in physical harm, pain or mental anguish. When an incident of abuse was suspected, facility management were to be notified immediately. All allegations of abuse were to be reported not later than 2 hours after the allegation was made, to the administrator and other officials, including the SA, in accordance with State law.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		9/18/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	C 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 4 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care planned interventions were implemented for 2 of 2 residents (R1,R2) who were observed in close	F 656	1. Staff educated on the importance of following care plans and keeping residents separated after a physical altercation.	

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 5 proximity to each other after a physical altercation had occurred and staff were directed to keep them separated. Findings include: R1's quarterly Minimum Data Set (MDS) dated 5/27/22, indicated R1 had severe cognitive deficits with diagnoses that included Downs syndrome (a genetic disorder associated with physical growth delays, charachteristic facial features and developmental and intellectual diabilities), major depressive disorder with psychotic episodes, muscle wasting and atrophy, history of physical and sexual abuse in childhood, osteoarthritis, and Alzheimer's disease. R1 was unsteady but able to walk independently using a four-wheeled walker. R1's care plan dated 8/24/22, indicated R1 had an activities of daily living (ADL) deficit due to cognitive losses from Alzheimer's dementia, Downs syndrome, major depression with psychotic symptoms, and osteoarthritis (inflammation of onr or more joints) Interventions indicated R1 was not to interact in personal contact with R2. R1's nursing assistant (NA) Kardex Report dated 8/24/22, indicated to separate R1 from R2 and not allow for personal contact between the two residents due to an incident that occurred on 8/20/22. Staff were also to redirect R1 when she appeared at risk or doing something that might cause distress to her or others or put R1 in a potentially dangerous situation. R1's progress note dated 8/20/22, indicated R2 pulled R1's hair near the dining room and lobby.	F 656	2. All residents have the potential to be affected by this type of situation. All residents care plans and POC documentations were reviewed to ensure that interventions for behaviors are updated accordingly. 3. All staff to be re-educated on the importance of following interventions listed in care plans. RN Managers or designee to ensure POC documents are updated according to interventions in care plans. 4. Social Services or designee will monitor care plans to coincide with behavioral interventions. Audits will be conducted weekly for four weeks then as needed to ensure interventions are being followed. Any issues found will be brought to QAPI.	

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 6 R2's quarterly MDS dated 7/27/22, indicated R2 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS) assessment. R2 had diagnoses that included dementia with behavioral disturbance, major depressive disorder, anxiety, Alzheimer's disease, and delusional disorder. R1 required a wheelchair for mobility. R2's care plan dated 8/24/22, indicated R2 had the potential to be verbally aggressive related to severe cognitive impairment, dementia, and ineffective coping skills. Interventions included keeping R2 separated from R1 due to an incident that occurred on 8/20/22. R2's NA Kardex Report dated 8/24/22, indicated to keep R2 separated from R1 due to an incident that occurred between the two of them on 8/20/22. R2's progress note dated 8/20/22, indicated R2 pulled R1 down to the ground by her hair in the hallway near the dining room and lobby. R2 and R1 were separated immediately. During an interview on 8/23/22, at 12:20 p.m. R1 was sitting in a recliner in her room and stated R2 pulled her down to the ground a few days ago. R1 stated R2 had not hurt her since then but had "said things to me." R1 stated she saw R2 a lot and worried she would come into R1's room because R2 lived across the hall from R1. During a continuous observation on 8/23/22, from 2:50 p.m. to 3:05 p.m. R2 was in her room sitting in her wheelchair when trained medical assistant (TMA)-A and NA-A entered her room to reposition	F 656		

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7 R2 in her wheelchair. At the same time R1 walked up and stood in R2's doorway. TMA-A and NA-A exited R2's room, walking past R1 in the doorway. No redirection was offered to R1. R1 then entered R2's room, locked her walker within two feet of R2, walked to R2's wheelchair and hugged her. No staff were present in hallway. R1 stated "I like you. You're my friend. Are you ok now?" R2 appeared confused and did not know how to respond, however, remained pleasant. R1 continued to tell R2 she liked her and asked if she was okay. R2 continued to appear confused but remained calm. R1 walked out of R2's room and R2 followed, using her feet to propel her wheelchair. R1 and R2 stopped at the nurse's cart in the hallway where licensed practical nurse (LPN)-A was preparing resident medications. LPN-A redirected R1 to the hallway behind him and repositioned R2 beside R1 within two feet of each other. LPN-A turned back to his care and continued to prepare resident medications for administration. No attempt was made to separate R1 and R2. At 3:05 p.m. R1 walked down hallway towards the lobby and R2 remained behind LPN-A. During an interview on 8/23/22, at 3:11 p.m. LPN-A stated he was unaware of any incident occurring between R1 and R2 on 8/20/22, or that they should be separated from each other. During an interview on 8/23/22, at 3:33 p.m. TMA-A stated although he was not working on 8/20/22, he was aware that R2 and pulled R1 to the ground by her hair and that staff were to keep them separated. TMA-A further stated R1 often approached R2 but he was unaware R1 had entered R2's room after he and NA-A repositioned R2. TMA-A further stated there was	F 656		

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 a sign off sheet at the desk a couple of days ago for the staff to acknowledge they were to keep R1 and R2 separated. During an interview on 8/23/22, at 3:42 p.m. NA-B stated although he was familiar with R1 and R2, he was unaware of the incident that occurred between R1 and R2 on 8/20/22, and did not receive education to keep them separated. During an interview on 8/24/22, at 11:47 a.m. registered nurse (RN)-A stated she was aware R2 had pulled R1 to the ground by her hair and staff were expected to keep the two residents separated from each other. If staff saw R1 and R2 together, staff were to redirect them away from each to avoid any further altercations. During an interview on 8/24/22, at 1:07 p.m. social worker (SW)-A stated after the incident between R1 and R2 on 8/20/22, both resident care plans were updated with interventions to keep the residents separated. SW-A further stated it would be concerning for the safety of both R1 and R2, if they were not separated from each other and that staff should follow resident care plans. During an interview on 8/24/22, at 1:51 p.m. administrator stated he believed R1's and R2's care plans were updated after their physical altercation on 8/20/22, and staff should have followed the resident's care plans to ensure proper care and safety of the residents. The facility Care Plans-Comprehensive policy undated, indicated each resident's care plan was designed to incorporate identified problem areas and risk factors associated with identified	F 656		

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9 problems.	F 656		

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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: On 8/23/22, and 8/24/22,, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaints were found to be substantiated: H53044233C (MN85692), with a deficiency cited at 1980 H53044269C (MN86134), with a deficiency cited at 1980 and 0565 and The following complaints were found to be unsubstantiated, H53044247C (MN86109) H53044232C (MN86094) H53044290C (MN86167) 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing	2 000		

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of abuse was reported to the State Agency (SA) for 1 or 2 residents (R4) after R4 was hit by another resident (R2). Findings include:	2 565	1. Staff educated on the importance of following care plans and providing care to residents as directed by the care plan. 2. All residents have the potential to be affected by this type of situation. All residents care plans and POC	9/18/22

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3 R2's quarterly MDS dated 7/27/22, indicated R2 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS) assessment. R2 had diagnoses that included dementia with behavioral disturbance, major depressive disorder, anxiety, Alzheimer's disease, and delusional disorder. R2 required a wheelchair for mobility. R2's progress note dated 7/30/22, indicated R2 hit R4 at 3:00 p.m. while they were side-by-side in the hallway. "The ED [executive director] and DON [director of nursing] were notified." R2's Risk Management form dated 7/30/22, indicated R2 was in the hallway talking to herself when R4 wheeled by her on his way out of the facility to smoke a cigarette. R2 grabbed R4's smoking apron, unfastened the velco, and hit R4 in the chest. R4's quarterly Minimum Data Set (MDS) dated 6/6/22, indicated R4 had no cognitive deficits and used a wheelchair for mobility. R4's diagnoses included schizophrenia, morbid obesity, bipolar disorder, chronic pain syndrome, anxiety, and attention deficit-hyperactivity disorder. R4's progress note dated 7/30/22, indicated R4 was hit in the chest and had his smoking apron partially ripped off by R2 when they passed each other in the hallway. R4's progress note indicated the ED and DON were notified. R4's Risk Management form dated 7/30/22, indicated and R4 was going down the hallway R2 reached out and hit R4 in the chest. R4 stated he was going out to smoke when R2 "off and hit me in the chest".	2 565	documentations were reviewed to ensure that they are accurate and updated. 3. All staff to be re-educated on the importance of following the care plan when providing care to residents. RN Managers or designee to ensure POC documents are updated according to care plans. 4. DON or designee will monitor care plans to coincide with care staff when providing direct care. Audits will be conducted weekly for four weeks then as needed to ensure care plans are being followed. Any issues found will be brought to QAPI.	

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4 During an interview on 8/23/22, at 12:47 p.m. R4 stated approximately two weeks ago, he was wheeling himself down the hallway when R2 grabbed his smoking apron off of him and hit him. R4 stated he told staff about the incident but could not recall who. During an interview on 8/24/22, at 1:51 p.m. the administrator stated he was sure the staff did Risk Management forms regarding the altercation between R2 and R4 but he could not remember the specifics. The administrator stated he did not believe the incident needed to be reported to the SA because R4 did not sustain any injuries and indicated he felt safe at the facility. The facility Reporting Abuse to Facility Management dated 9/4/20, indicated abuse was the willful infliction of injury or intimidation resulting in physical harm, pain or mental anguish. When an incident of abuse was suspected, facility management were to be notified immediately. All allegations of abuse were to be reported not later than 2 hours after the allegation was made, to the administrator and other officials, including the SA, in accordance with State law. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 5	21980		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead	21980		9/18/22

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 6 agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of abuse was reported to the State Agency (SA) for 1 or 2 residents (R4) after R4 was hit by another resident (R2). Findings include: R2's quarterly MDS dated 7/27/22, indicated R2 had severe cognitive deficits and was unable to complete the Brief Interview for Mental Status (BIMS) assessment. R2 had diagnoses that included dementia with behavioral disturbance, major depressive disorder, anxiety, Alzheimer's disease, and delusional disorder. R2 required a wheelchair for mobility. R2's progress note dated 7/30/22, indicated R2 hit R4 at 3:00 p.m. while they were side-by-side in the hallway. "The ED [executive director] and DON [director of nursing] were notified." R2's Risk Management form dated 7/30/22, indicated R2 was in the hallway talking to herself when R4 wheeled by her on his way out of the	21980	1. Staff educated on the importance of reporting all allegations of abuse or neglect within the required timeframe. IDT staff educated on the required timeframe of reporting such allegations. 2. All residents have the potential to be affected by this type of situation. 3. All staff to be re-educated on policies and procedures of reporting allegations of abuse or neglect according to policy and required timeframe. 4. Administrator or designee will audit all complaints of alleged abuse or neglect to ensure reports are filed within the required timeframe. Administrator or designee will conduct audits of complaints weekly for four weeks, monthly for three months, then ongoing as needed. Any issues identified will be brought to QAPI.	

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 7 facility to smoke a cigarette. R2 grabbed R4's smoking apron, unfastened the velco, and hit R4 in the chest. R4's quarterly Minimum Data Set (MDS) dated 6/6/22, indicated R4 had no cognitive deficits and used a wheelchair for mobility. R4's diagnoses included schizophrenia, morbid obesity, bipolar disorder, chronic pain syndrome, anxiety, and attention deficit-hyperactivity disorder. R4's progress note dated 7/30/22, indicated R4 was hit in the chest and had his smoking apron partially ripped off by R2 when they passed each other in the hallway. R4's progress note indicated the ED and DON were notified. R4's Risk Management form dated 7/30/22, indicated and R4 was going down the hallway R2 reached out and hit R4 in the chest. R4 stated he was going out to smoke when R2 "off and hit me in the chest". During an interview on 8/23/22, at 12:47 p.m. R4 stated approximately two weeks ago, he was wheeling himself down the hallway when R2 grabbed his smoking apron off of him and hit him. R4 stated he told staff about the incident but could not recall who. During an interview on 8/24/22, at 1:51 p.m. the administrator stated he was sure the staff did Risk Management forms regarding the altercation between R2 and R4 but he could not remember the specifics. The administrator stated he did not believe the incident needed to be reported to the SA because R4 did not sustain any injuries and indicated he felt safe at the facility. The facility Reporting Abuse to Facility	21980		

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 08/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 8 Management dated 9/4/20, indicated abuse was the willful infliction of injury or intimidation resulting in physical harm, pain or mental anguish. When an incident of abuse was suspected, facility management were to be notified immediately. All allegations of abuse were to be reported not later than 2 hours after the allegation was made, to the administrator and other officials, including the SA, in accordance with State law. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		