Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2022

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

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

Dear Administrator:

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

On May 27, 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. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On May 26, 2022, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 June 23, 2022, will remain in effect.

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

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 June 23, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 23, 2022.

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

As we notified you in our letter of May 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 June 23, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 5, 2022 (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

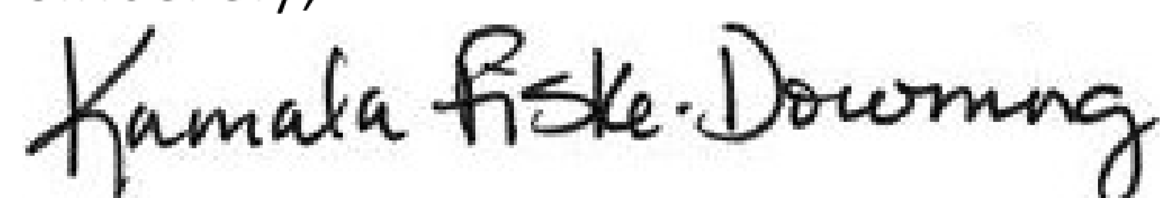
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING ______ B. WING ______	C 05/27/2022

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 5/25/22 - 5/27/22, 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 complaint was found to be SUBSTANTIATED: H53041693 (MN83593). The survey resulted in an Immediate Jeopardy (IJ) at F880 Infection Control when R1 and R2, who were both diagnosed with Covid-19 on 5/16/22 and placed on isolation were observed transporting themselves through the hallway to the facility public smoking area. R1 was not wearing a face mask and R2 was outside in the designated smoking without a facemask within 6 feet of other residents and visitors. The director of nursing (DON), along with registered nurse (RN)-A and licensed practical nurse, (LPN)-B were notified of the IJ on 5/25/22, at 6:00 p.m. The IJ was removed on 5/26/22, at 4:46 p.m., but non-compliance remained at the lower level and severity of D - isolated scope and severity, which indicated no actual harm with but more than minimal harm that is not IJ. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 06/29/2022

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

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F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	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 interview and document review, the facility failed to identify a root cause for falls, implement, monitor and/or revise interventions to ensure efficacy for 1 of 3 residents (R3) reviewed for falls. R3 had 12 falls in 3 months and care planned interventions were not changed. This resulted in harm for R3 who sustained 3 fractured metatarsals (toes) and a sprained ankle during a fall on 5/15/22. Findings include: R3 face sheet, undated, indicated on 1/31/22 at 3:03 p.m. R3 was admitted to the facility from the hospital after ankle surgery. Admission fall assessment dated 1/31/22 indicted R3's level of consciousness/mental status included intermittent confusion, ambulatory incontinent and adequate vision. Gait/balance was not performed but, R3 had no drop of systolic blood pressure between lying and standing. Medication status included R3 took 3 -4	F 689	F tag 689 Element 1: Resident # 3's care plan was reviewed by the IDT team on 6/17/2022 and updated with specific interventions related to the possible causes of falls. Goal and interventions were revised. Element 2: All residents at risk for falls will be potentially affected by this deficiency. IDT team will review all residents care plans to ensure appropriate interventions are in place. Element 3: The ADON or designee will in-service all staff on falls policy and procedure. In services will be initiated 6/17/2022. All staff will have an in-service quarterly regarding falls policy and procedure. All new hire employees will be educated regarding falls policy and procedure, and also during orientation.	6/17/22

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F 689	Continued From page 2 antipsychotic agents, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that cause lethargy or confusion. R3 did not have predisposing diseases such as circulatory/heart, neuromuscular/functional, orthopedic, perceptual, psychiatric/cognitive, infection, pain/headache, fatigue/weakness, weight loss, Vitamin D deficiently or history of falls. Giving her a score of 15 indicating a high risk for falls. Nursing progress note dated 2/2/22, at 12:03 a.m. indicated R3 was found on the floor sitting in front of her wheelchair. R3 reported to staff she was attempting to put herself to bed and she hit the right side of her head. Vital signs and neurochecks were completed. Intervention documented in progress notes was to put R3 by the nurse's station when up in wheelchair. This intervention was not on the plan of care. Nursing progress note dated 2/8/22, at 8:35 p.m. indicated R3 had fallen from her wheelchair at 4:10 p.m. R3 reported to staff she was attempting to get herself back into bed from her wheelchair. No injuries were reported of observed. Progress note indicated that staff need to be reminded again that if resident is alone in her wheelchair she cannot be left alone. Nursing progress note dated 2/9/22, at 2:52 p.m. indicated R3 was able to move all extremities. Resident was alert. Fall mat placed next to bed. Bed in lowest position, call light within reach. Care plan dated 2/18/22 indicated the focus for fall risk for R3 was related to confusion, deconditioning, gait/balance problems,	F 689	Element 4: The RN unit managers will audit falls risk management reports to ensure that care plan interventions are updated appropriately for the cause of fall and further fall prevention. This will be done monthly for 3 months, then quarterly thereafter and the result of the QAPI will be submitted to the Administrator and QAPI committee for review and further discussion. Completion 6/17/22	

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F 689		F 689		

Continued From page 3
incontinence, poor communication/comprehension, psychoactive drug use, unaware of safety needs, and vision/hearing problems. "Resident has had one fall with minor injury since admission." The care plan goal identified R3 will not sustain serious injury through the review date. The care plan interventions included, to anticipate and meet resident's needs. Call light within reach. Resident while in bed is to be in the lowest position with non-alarmed fall mat next to bed. Review information on past falls and attempt to determine cause of falls. Record possible root causes. After remove any potential causes if possible. Educate resident/family/caregiving/IDT as to causes.

Nursing progress note dated 2/23/22, at 9:03 p.m. indicated at 8:21 p.m. R3 crawled out of bed, R3 stated to staff she wanted to get out of bed, she was incontinent of bowel. Resident was cleaned up and returned to bed no injuries were reported.

Nursing progress note dated 2/27/22, at 7:49 p.m. indicated at 6:45 p.m. R3 was found on the floor on her mat by the bedside, no injuries were noted.

Nursing progress note dated 3/4/22, at 7:58 p.m. R3 had an unwitnessed fall, no injuries observed. Vital signs were taken.

Nursing progress note dated 3/6/22, at 6:10 a.m. indicated R3 was found seated on her bottom on the other side of her mat on the floor trying to get her bra on, no injuries noted. Vital signs were taken.

Nursing progress note dated 3/8/22, at 3:24 a.m.

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F 689	Continued From page 4	F 689		

indicated R3 was found on her mat at 1:58 p.m., no injuries were noted, R3 seemed to have slid off her bed onto the padding.

Nursing progress note dated 3/13/22, at 3:00 p.m. indicated R3 was found sitting on her bottom next to her mat. She denied pain, or a head strike to staff. R3 stated to staff "I was trying to get into my wheelchair because I am ready to eat dinner. R3 had her call light in place and fall mat in place.

Nursing progress note dated 3/15/22, at 8:34 p.m. indicated a fall assessment was completed due to reentry from a hospital with the diagnosis of a urinary tract infection.

Fall Assessment dated 3/15/22, indicated R3's level of consciousness/mental status included intermittent confusion, ambulatory incontinent, adequate vision. Gait/balance was not performed but, R3 had no drop of systolic blood pressure between lying and standing. Medication status included R3 took 1-2 antipsychotics, antianxiety agents, antidepressants, hypnotics, cardiovascular medications, diuretics, narcotic analgesics, neuroleptics, or other medications that cause lethargy or confusion. R3 had 1-2 predisposing diseases such as circulatory/heart, neuromuscular/functional, orthopedic, perceptual, psychiatric/cognitive, infection, pain/headache, fatigue/weakness, weight loss, Vitamin D deficiently or history of falls. Giving her a score of 17 indicating a high risk for falls.

Nursing progress note dated 4/11/22, at 1:18 p.m. R3 was found on the floor, R3 complained to staff mild pain to the right palm of the hand. Purplish discoloration was noted on right upper outer thigh and purplish discoloration noted on right hand, R3

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F 689	Continued From page 5	F 689		

denied pain. Care plan updated.

Care plan dated 4/25/22, at indicated the fall risk lacked any changes to the focus, goals, or interventions.

Nursing progress note dated 5/12/22, at 3:35 p.m. indicated R3 was found on the floor. R3 stated to staff she had wanted to go for a walk. R3 complained of right knee pain, small bruising noted. X-rays taken on 5/12/22 and were negative.

Nursing progress note dated 5/15/22, at 10:55 p.m. indicated R3 was found on the floor away from her bed, near the bathroom. R3 reported a head strike, where a small bump/protrusion was present neuro-checks assessment stated were completed.

Nursing progress note dated 5/16/22, at 7:43 a.m. R3 was complaining of left foot/ankle pain, slight swelling, but no bruising or redness. R3's physician was notified and ordered R3 to be sent to the ER.

Care plan dated 5/16/22, was updated. The fall risk focus was updated to read, the resident is at risk for falls, related to confusion, deconditioning, gait/balance problems, incontinence, poor communication/comprehension. Psychoactive drug use. Unaware of safety needs and vision/hearing problems. The care plan goals and interventions were not changed.

Hospital After Visit Summary dated 5/16/22, indicated R3 had a fracture foot second metatarsal closed, fracture foot third metatarsal closed, fracture foot fourth metatarsal closed

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F 689	Continued From page 6	F 689		

Nursing progress note dated 5/16/22, at 9:55 a.m. R3 returned from the ER with a diagnosis of fractures of the 2nd, 3rd, and 4th metatarsals of the left foot. Orders for rest, compression, elevate and ice. Oxycodone 5mg 1 tablet every 6 hours as needed for pain.

Significant change MDS dated 5/26/22, indicated R3 had a BIMs score of 99 indicating severe cognitive impairment. R3 needed extensive assistance with bed mobility, transfers, locomotion, and dressing. R3s diagnosis was orthopedic aftercare fracture of left lower leg, ankylosing spondylitis (degenerative arthritis of the spine), intellectual disabilities, and obesity.

Upon interview on 5/25/22 at 11:32 a.m. nursing assistant (NA)-A reported R3 got for meals, then laid down right away. She often tries to transfer herself. She is educated every time we go in her room. She gets it, but doesn't get it." She has the mat by bed, and we help her with cares. NA-A denied being told to have R3 by the nurse's station. "We do check on her often and he has the falling star by her door, which means to check on her often." NA-A did not identify how often R3 is checked on and stated it is not documented for specific times.

Upon interview on 5/25/22, at 12:02 p.m. registered nurse, (RN)-D reported R3 for the fall risk concerns, R3 is offered toileting, has safety checks and she was monitored for pain. RN-D could not provide documentation of specifics such as how often, who is responsible or where toileting and pain monitoring is documented. RN-D reported that R3s room visual of the nurse's station. R3 could not be seen in her room

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F 689	Continued From page 7	F 689		

Continued From page 7
from the nurse's station but can be heard when she yells out instead of using the call light. RN-D stated R3 has the mat beside her bed to remind her not to get up out of her bed as much as she did in the past on her own.

Upon interview on 5/25/22, at 12:30 p.m. RN-A reported that her expectation of the floor nurses is for an incident report to be filled out and notifications be made. The residents should have an assessment done after each fall and new interventions placed on residents. A change of condition would be completed for a fall with an injury. RN-A was not certain which assessments would be completed, as "it's the floor nurses who do them mainly." RN-A directed the surveyor to speak with the MDS coordinator.

Upon interview on 5/25/22, at 1:01 p.m. RN-C, minimal data set coordinator, reported his expectation is for staff to place interventions with each fall, and those interventions would come from the assessments, which could include Fall risk, bed rails, range-of-motion/mobility, pain, and transfer assessments. "Any other assessment could be done as well as elopement, smoking, or Braden if concerns arose."

Facility Policy Fall Rick Assessment dated 10/4/21, indicated the nursing staff in conjunction with the attending physician, consultant pharmacist, therapy staff and others will seek to identify and document resident risk factors for falls an establish a resident-centered falls prevention program. Upon admission, the nursing staff and physician will review the residents record for a history of falls, especially falls in the last 90 days and recurrent of period bouts of falling over time.

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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 689	Continued From page 8 Facility policy Assessing Falls and Their Causes dated 10/4/21, The residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly.	F 689		
F 842 SS=F	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		6/17/22

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F 842	Continued From page 9 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain complete and accurately documented assessements to identify	F 842	F Tag 842 Element 1: All overdue assessments for R# 3 and R#5 will be completed by	

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F 842

Continued From page 10

risk factors for pain, nutrition, and fall risk for 3 of 3 residents (R3, R4, and R5) reviewed for assessments. R3 suffered 12 falls, R4 who suffered 6 falls and R5 who suffered 3 falls from 1/1/22 until 5/26/22.

Findings include:

Minimal Data Set (MDS) significant change dated 4/11/22, indicated R4 had a Brief Inventory of Mental Status (BIMs) score of 99 indicating severe cognitive impairment. R4 had a significant diagnosis of Schizophrenia, Age -related Cognitive decline, obesity. Care Area Assessment CAA indicated R4 needed extensive assistance with Bed mobility and transfers. Falls were triggered indicating R4 had balancing problems moving from a seated position, walking with an assistive device, turning, and moving on and off the toilet and has fallen. R4 triggered for pain, intensity documented as a 9/10 (0 being no pain, and ten as the worst pain you can imagine).

Standard Assessment dated 5/27/22, show that R4s last fall risk assessment was 1/22/22. Per Facility Incentidents by Document Type dated 5/26/22 indicated R4 had falls on 1/16/22, 2/3/22, 3/27/22, 4/16/22, 4/25/22 and 4/28/22.

Upon record review dated 5/27/22, R4's quarterly resident assessment, resident R4's assesments were overdue: pain tool observation was due on 4/28/22 and Pain Interview (MDS) with pain management review was due on 4/30/22, fall risk assessment, range of motion and mobility were due 4/27/22.

Mayo Clinic After Visit Summary dated 5/16/22, indicated R3 had a fracture foot second

F 842

6/17/2022. R# 4 has since deceased.

Element 2: All residents have the potential to be affected by this deficiency. All resident's assessments will be audited by the IDT on 6/17/2022.

Element 3: DON or designee will in-service all nursing staff on assessment schedules and completion. The MDS coordinator will assign specific assessments for each shift. New nursing hires will be educated regarding assessments and completion of assessments upon hire and quarterly.

Element 4: MDS coordinator or designee will audit all resident's medical records monthly for 3 months and then quarterly thereafter to ensure all assessments are up to date. Report of assessments and completion will be brought to QAPI for review.

Completion date 6/17/22

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F 842	Continued From page 11	F 842		

metatarsal closed, fracture foot third metatarsal closed, fracture foot fourth metatarsal closed and Sprained ankle.

Upon document review an email dated 5/26/22 facility reported R3 had fallen at facility 2/1/22, 2/8/22, 2/29/22, 2/23/22, 3/4/22, 3/6/22, 3/13/22, 4/11/22, 4/17/22, 5/10/22, 5/12/22 and 5/15/22.

Upon document review of significant change MDS dated 5/26/22 indicated R3 had a BIMs score of 99 indicating severe cognitive impairment. R3 needed extensive assistance with bed mobility, transfers, locomotion, and dressing. R3s diagnosis was orthopedic aftercare fracture of left lower leg, ankylosing spondylitis (degenerative arthritis of the spine), intellectual disabilities, and obesity.

Standard Assessment dated 5/27/22, indicated R3 had Resident fall risk assessments on 1/31/22 (admission) and 3/15/22 (reentry). No other fall assessments completed. R3 had nurse pain tool observation on 3/16/22. R3's assesments were overdue: Nutritional Date (Quarterly) MNA due 4/21/22, Quarterly Resident Review due 4/29/22, CDL-Centennial Quarterly Nutritional Assessment V-2, Lift Mobility, ROM, and Mobility due 5/1/22.

Upon document review of significant change MDS dated 4/30/22, R5 needed extensive assistance with bed mobility, transfers, and dressing. R5 had a BIMs score of 9 indicating moderate cognitive impairment. R5's diagnosis were Fracture of the shaft of humerus, left arm, spondylosis, and morbid obesity.

Upon document review an email dated 5/26/22, the facility reported R5 had fallen 3/29/22, 5/19/22

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F 842	Continued From page 12 and 5/23/22. Standard Assessment dated 5/27/22, R5s had Fall Risk Assessments completed 2/15/22 (admission) and 3/31/22 (ReEntry). R5's assesments were overdue: Nurse Pain Tool Observation was due 2/15/22, Functional Abilities and Goals - Admission were due 2/17/22, Pain Interview was due 2/17/22, Nutrition Data (Quarterly) MNA were due 5/6/22, Resident Quarterly Review V2, CDL, Centennial Quarterly Nutritional Assessment V2, Range of Motion and Mobility V2 and Elopement Risk Evaluation were due 5/15/22. Upon interview on 5/26/22 at 3:17 p.m. registered nurse (RN)-A stated the nurses on the floor do the assessments, she stated that if a resident has an incident an assessment needs to be done right away. RN-A reported in the event of each fall a fall assessment should be completed and interventions applied. For standard facility assessments, she was uncertain as to when and what assessments are complete. "You will have to ask the MDS nurse." Upon interview on 5/26/22 at 3:48 p.m. RN-C reported when a resident is readmitted to the facility the assessments completed are Braden, Pain, elopement, bowel, and bladder, fall risk, bed rails, range or motion and mobility and transfer assessment and these need to be completed within 7 days. No assessments should not be overdue in the system. Facility Policy Fall Rick Assessment dated 10/4/21, indicated the nursing staff in conjunction with the attending physician, consultant pharmacist, therapy staff and others will seek to	F 842		

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F 842	Continued From page 13 identify and document resident risk factors for falls an establish a resident-centered falls prevention program. Upon admission, the nursing staff and physician will review the residents record for a history of falls, especially falls in the last 90 days and recurrent of period bouts of falling over time. Facility policy Assessing Falls and Their Causes dated 10/4/21, The residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly. Significant change policy and facility required assessments were requested however not received.	F 842		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		6/17/22

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F 880	Continued From page 14 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. §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.	F 880		

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F 880	Continued From page 15	F 880		

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 develop a system to ensure residents who were Covid-19 positive and smoke maintain isolation from other residents, staff, and visitors for 2 or 2 residents (R1 and R2) reviewed for infection control. The lack of an infection control system had the potential of serious harm in spreading Covid-19 to any residents, staff, and visitors who came in contact with R1 and R2 who required isolation.

The IJ began on 5/16/22, at 1:40 p.m. when R1 and R2 were diagnosed with Covid-19, placed on droplet isolation precautions, and were allowed to break isolation to smoke exposing other residents, staff, and visitors to Covid-19 in the facility and in the smoking area located at the front entrance of the building.

Findings include:

R2's progress notes dated 5/16/22, indicated R2 was positive for Covid-19. Physician orders 5/16/22, indicated R1 was to be placed on droplet isolation precautions; gown gloves, N95 and face shield for staff to wear at all times. The door was to remain closed at all times. All services were to be brought to resident while in isolation.

Upon observation on 5/25/22, from 2:30 p.m. to

F880

Element #1 A policy and procedure regarding Smoking Policy and Procedure for Covid 19 Positive Residents during Covid outbreaks was developed on 5/25/22. Resident's involved were educated by the social worker and MDS coordinator regarding the new smoking policy and procedure for the Covid positive residents and given a copy of the policy and procedure. Care plans updated for resident's involved to reflect the new policy.

Element 2 All residents which smoke can be potentially affected by the deficiency.

Element 3 All Staff on the site on 5/26/22 will be educated regarding the smoking and procedure for Covid Positive r3sidents. Staff that are not present or are not scheduled will be contracted verbally educated, those which can can not contact will not be allowed to work until they are educated.

Social worker will send out a mass communication message on 5/26/22 to all residents and family members informing

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F 880	Continued From page 16 3:08 p.m. R2 was observed outside in the smoking not wearing a mask. Two other unknown residents were observed smoking in the designated area during this time, as well as three visitors who need to pass through the designated smoking area to enter the main entrance of the building. R2 was seen coming in the front door at 3:08 p.m. after going outside and smoking. R2 walked back into the facility wearing a source control mask, passing by one unmasked resident and two source control masked visitors. R2 was within six feet of the staff and two visitors. R2 did not alert staff before entering the facility. Upon interview on 5/25/22, at 2:30 p.m. the receptionist identified R2 who is R1's roommate who was also Covid-19 positive was currently outside in the smoking area. Upon interview on 5/25/22, at 3:13 p.m. the director of nursing, (DON) verified witnessing R2 returning from being outside smoking without staff assistance walking the hallways. The DON stated "No that is not o.k." R2 has the same plan as R1 for smoking rights while Covid-19 positive. R1's progress notes dated 5/16/22, indicated R1 was positive for Covid-19. Physician orders 5/16/22, indicated R1 was to be placed on droplet isolation precautions; gown gloves, N95 and face shield for staff to wear at all times. The door was to remain closed at all times. All services were to be brought to resident while in isolation. Upon record review an email on 5/17/22, indicated the IDT team met and discussed the smoking rights for R1. The email indicated R1 could smoke if he chooses to. Staff spoke with R1 about using his call light to inform staff he	F 880	them of the new Smoking Policy and Procedure for Covid Positive residents during Covid Outbreaks. Elements 4 At the completion of a Covid outbreak any issues identified regarding residents and the said smoking policy and procedure will be discussed at QA/QAPI. Element 5 Completion date 6/17/22	

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F 880	Continued From page 17 wanted to go out to smoke so staff could clear the hallways and ensure no one else is outside smoking. Then when he is done, he will have to ring the doorbell to alert staff he is coming in the building again so staff can clear the hallway. R1 was to wear mask. R1 was agreeable. On 5/25/22, at 12:36 p.m. R3 asked the surveyor if she was aware that R1 is Covid-19 positive and goes out to smoke. Upon observation on 5/25/22, at 12:36 p.m. R1 was seen coming in the front door main entrance from outside after returning from the designated smoking area. R1 was wheeling himself down the hall without a facemask. R1 wheeled from the front entrance, passing through the commons area, down the resident room hallway, passing a nursing station where NA-A and NA-B were standing, then to his room. Nursing assistant (NA)-A and NA-B were in the hallway when R1 returned from outside. R1 was within six feet of both NA's. The NAs did not instruct R1 to put on a mask. Upon interview on 5/25/22, at 2:09 p.m. NA-A and NA-B verified they witnessed R1, who they identified as Covid-19 positive, had gone out smoking and returned at 12:36 without wearing a mask or alert staff he was coming into the building. NA-B stated "He sneaks out without getting staff assistance. I did not know he was to ring the doorbell for assistance when he is done smoking, this was not told to the staff and is not on his list of cares." Upon interview 5/25/22, at 2:20 p.m. RN-A verified witnessing R1 coming in from smoking as he passed her office without staff accompanying	F 880		

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F 880	Continued From page 18	F 880		

him. RN-A stated, "He has the right to smoke."

Upon interview on 5/25/22, at 3:56 p.m. R3 stated R1 and R2 go outside all the time to smoke without notifying staff. The rule for smokers with Covid-19 has always been the same, to notify staff, clear the hallways when they come and go to smoke, but it was never done for R1 and R2. R3 stated he worried he will get Covid-19 and not be able to have a surgery he needs next week.

Upon observation on 5/26/22, at 2:21 p.m. LPN-A brought out R1 and R2 to smoke. R1 was moving faster than R2 and got ahead LPN and R2. R1 got himself around the corner of the commons area without LPN checking to see if any residents, staff, or visitors were present.

Upon interview on 5/26/22, at 2:26 p.m. RN-B reported witnessing that LPN-A did not check the commons area prior to R1 entering the area.

Upon interview on 5/26/22, at 4:12 p.m. R1 reported understanding the email dated 5/17/22 and was glad that it was just one more day as even with Covid-19 he went out and smoked as he pleased, "sometimes staff assisted me and sometimes not."

Upon interview on 5/26/22, at 4:17 p.m. R2 stated understanding the email dated 5/17/22 and get he was off isolation the following day as the conditions of the plan were too harsh.

The IJ which began on 5/16/22, at 1:40 p.m. was removed on 5/26/22, at 4:46 p.m. when it was verified through observation, interview and document review facility implemented a systemic removal plan when it was observed LPN-A

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F 880	Continued From page 19 checked the hallways and brought R1 and R2 out to smoke. They all transported together, LPN-A stayed outside in the Covid-19 smoking area with R1 and R2 and escorted them back to their room with no residents, staff, and visitors in contact with R1 and R2. An acceptable Covid-19 smoking policy reviewed on 5/26/22, the facility provided education to all staff were working regarding the Covid-19 smoking policy on 5/26/22. All facility staff, who had not worked, were notified about the Covid-19 smoking training must be completed prior to their next scheduled shift.	F 880		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
June 17, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: Z04J11

Dear Administrator:

The above facility was surveyed on May 25, 2022 through May 27, 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.

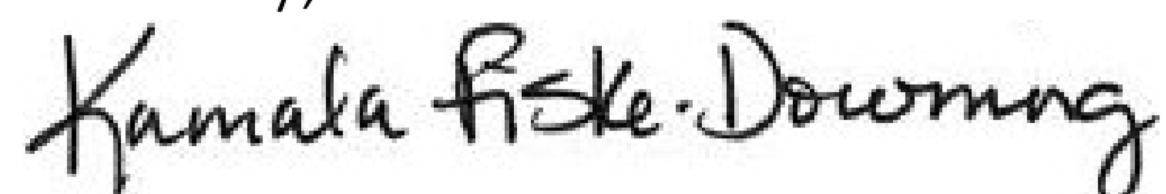
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule 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: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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
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

Minnesota Department of Health

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 05/27/2022

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	2 000		

*****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 5/25/22 - 5/27/22, a complaint survey was conducted at your facility by surveyors 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.

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53041693 (MN83593). 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 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	2 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by:	21390		6/29/22

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21390	Continued From page 3 Based on observation, interview and document review, the facility failed to develop a system to ensure residents who were Covid-19 positive and smoke maintain isolation from other residents, staff, and visitors for 2 or 2 residents (R1 and R2) reviewed for infection control. The lack of an infection control system had the potential of serious harm in spreading Covid-19 to any residents, staff, and visitors who came in contact with R1 and R2 who required isolation. Findings include: R2's progress notes dated 5/16/22, indicated R2 was positive for Covid-19. Physician orders 5/16/22, indicated R1 was to be placed on droplet isolation precautions; gown gloves, N95 and face shield for staff to wear at all times. The door was to remain closed at all times. All services were to be brought to resident while in isolation. Upon observation on 5/25/22, from 2:30 p.m. to 3:08 p.m. R2 was observed outside in the smoking not wearing a mask. Two other unknown residents were observed smoking in the designated area during this time, as well as three visitors who need to pass through the designated smoking area to enter the main entrance of the building. R2 was seen coming in the front door at 3:08 p.m. after going outside and smoking. R2 walked back into the facility wearing a source control mask, passing by one unmasked resident and two source control masked visitors. R2 was within six feet of the staff and two visitors. R2 did not alert staff before entering the facility. Upon interview on 5/25/22, at 2:30 p.m. the receptionist identified R2 who is R1's roommate who was also Covid-19 positive was currently outside in the smoking area.	21390	Corrected	

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21390	Continued From page 4	21390		

Upon interview on 5/25/22, at 3:13 p.m. the director of nursing, (DON) verified witnessing R2 returning from being outside smoking without staff assistance walking the hallways. The DON stated "No that is not o.k." R2 has the same plan as R1 for smoking rights while Covid-19 positive.

R1's progress notes dated 5/16/22, indicated R1 was positive for Covid-19. Physician orders 5/16/22, indicated R1 was to be placed on droplet isolation precautions; gown gloves, N95 and face shield for staff to wear at all times. The door was to remain closed at all times. All services were to be brought to resident while in isolation.

Upon record review an email on 5/17/22, indicated the IDT team met and discussed the smoking rights for R1. The email indicated R1 could smoke if he chooses to. Staff spoke with R1 about using his call light to inform staff he wanted to go out to smoke so staff could clear the hallways and ensure no one else is outside smoking. Then when he is done, he will have to ring the doorbell to alert staff he is coming in the building again so staff can clear the hallway. R1 was to wear mask. R1 was agreeable.

On 5/25/22, at 12:36 p.m. R3 asked the surveyor if she was aware that R1 is Covid-19 positive and goes out to smoke.

Upon observation on 5/25/22, at 12:36 p.m. R1 was seen coming in the front door main entrance from outside after returning from the designated smoking area. R1 was wheeling himself down the hall without a facemask. R1 wheeled from the front entrance, passing through the commons area, down the resident room hallway, passing a nursing station where NA-A and NA-B were

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21390	Continued From page 5	21390		

standing, then to his room. Nursing assistant (NA)-A and NA-B were in the hallway when R1 returned from outside. R1 was within six feet of both NA's. The NAs did not instruct R1 to put on a mask.

Upon interview on 5/25/22, at 2:09 p.m. NA-A and NA-B verified they witnessed R1, who they identified as Covid-19 positive, had gone out smoking and returned at 12:36 without wearing a mask or alert staff he was coming into the building. NA-B stated "He sneaks out without getting staff assistance. I did not know he was to ring the doorbell for assistance when he is done smoking, this was not told to the staff and is not on his list of cares."

Upon interview 5/25/22, at 2:20 p.m. RN-A verified witnessing R1 coming in from smoking as he passed her office without staff accompanying him. RN-A stated, "He has the right to smoke."

Upon interview on 5/25/22, at 3:56 p.m. R3 stated R1 and R2 go outside all the time to smoke without notifying staff. The rule for smokers with Covid-19 has always been the same, to notify staff, clear the hallways when they come and go to smoke, but it was never done for R1 and R2. R3 stated he worried he will get Covid-19 and not be able to have a surgery he needs next week.

Upon observation on 5/26/22, at 2:21 p.m. LPN-A brought out R1 and R2 to smoke. R1 was moving faster than R2 and got ahead LPN and R2. R1 got himself around the corner of the commons area without LPN checking to see if any residents, staff, or visitors were present.

Upon interview on 5/26/22, at 2:26 p.m. RN-B reported witnessing that LPN-A did not check the

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21390	Continued From page 6 commons area prior to R1 entering the area. Upon interview on 5/26/22, at 4:12 p.m. R1 reported understanding the email dated 5/17/22 and was glad that it was just one more day as even with Covid-19 he went out and smoked as he pleased, "sometimes staff assisted me and sometimes not." Upon interview on 5/26/22, at 4:17 p.m. R2 stated understanding the email dated 5/17/22 and get he was off isolation the following day as the conditions of the plan were too harsh. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21390		