DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
August 24, 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 11, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility which constitutes **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 10, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

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

This Department is also recommending 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, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 8, 2022, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 11, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Terrace At Cannon Falls is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 11, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

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 "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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, Licensing and Certification Program 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 February 11, 2023 (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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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

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 08/11/2022

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 8/9/2022 to 8/11/2022 a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F689 began on 7/24/22, when based on observation, interview and document review, the facility failed to identify, assess, and implement interventions for all the 40 residents residing in the facility when the facilities call light system malfunctioned and was unusable to the residents. The facility's systemic failure resulted in the potential for serious harm, injury, impairment, or death to the residents which resulted in and immediate jeopardy (IJ). The administrator, and director of nursing (DON) were notified of the IJ on 8/10/2022 at 6:35 p.m. The IJ was removed on 8/10/2022 at 10 p.m. AND The above findings constituted Substandard Quality of Care and an extended survey was conducted on 8/15/2022. The following complaints were found to be SUBSTANTIATED: H53043736C (MN00085696) and H53043751C (MN00085666) with related deficienticies cited at F689, F839, F919, and F925. The following complaint was found to be	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2022

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 UNSUBSTANTIATED: H53043666C (MN00085697) 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 substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=L	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an effective resident call system, or means for residents to call for help, when the facility had a call light and wander guard system outage. This failure resulted in risk of serious harm, injury, impairment or death for 9 of 9 residents (R1, R3, R5, R6, R2, R7, R8, R9, and R11's) who were unable to summon assistance when needed, in	F 689	F689 – Free of Accident Hazards/Supervision/Devices 1. Residents that were identified as incapable of using bells in the interim were put on 15-minute checks to ensure safety. All remaining residents were instructed to utilize bells to call for assistance. This was then replaced with	9/3/22

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F 689	Continued From page 2 addition to the remaining 31 residents in the facility. The facility's systemic failure resulted in an Immediate Jeopardy (IJ) situation for 40 of 40 residents. The IJ began on 7/24/22, when after the call/WanderGuard system malfunctioned, the facility failed to identify, assess, and implement individualized resident call systems and safety interventions to meet residents needs. The administrator and director of nursing (DON) were notified of the IJ on 8/10/22 at 6:35 p.m. The IJ was removed on 8/10/22, at 10:00 p.m. when an acceptable plan was implemented. However, non-compliance remained at a lower scope and severity level F, that is widespread which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Two concerns were submitted to the state agency dated 8/1/2022 and 8/2/2022, which indicated the facility did not have a call light system in place and the resident's needs were not being met. The concern further indicated the facility's centralized call light system failed on approximately 7/29/2022, DON-A and Administrator implemented 15-minute checks but due to staffing shortages, the 15-minute checks were not getting done and all residents did not have a way to communicate their needs for assistance in their rooms or bathrooms which was leading to increased behaviors and resident needs not being met. R1's diagnoses included seizure disorder, hemiplegia, and depressive disorder. R1's	F 689	an interim radio call light system. Director of ES trained nurses on interim radio call light system. Nurses trained CNA's and both nurses and CNA's educated residents who have the dexterity to use the interim call light buttons. 2. All residents have the ability to be affected by this type of situation. Director of ES trained nurses on interim radio call light system. Nurses trained CNA's and both nurses and CNA's educated residents who have the dexterity to use the interim call light buttons. 3. 15-minute checks put in place right away. Excel spreadsheets created and staffing levels increased to accommodate the checks. One to two staff members per shift assigned to the checks. The leadership staff is available to assist. Vendors have been secured and a new call light system has been ordered. Install of baseplates in rooms started with projected completion date of overall system by the end of the month (9/2022). 4. Excel spreadsheet created to audit the interim call light system, to ensure that each button works. Director of ES or designee will conduct daily audits of interim call light system to ensure working order. Training of new system will be done by the Director of ES to nurse managers and leadership staff. Nurse managers will train nursing staff. Nurse managers and nursing staff will educate the residents on the system. Leadership team will assist with training the dietary aides, kitchen	

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F 689	Continued From page 3 admission minimum data set (MDS) 8/2/22, also included diagnoses of asthma/lung diseases, had moderate cognitive impairment, required oxygen, and had choking/coughing episodes during meals/swallowing medications. MDS further identified R1 to be dependent on staff assist with bed mobility, toileting, transfers with a mechanical lift, and repositioning. During observation and interview on 8/9/2022 at 2:10 p.m., R1 stated her call light didn't work. There was a ring of 8 jingle bells on the floor next to R1's wheelchair and R1 wearing a yellow bracelet with "fall risk" written on it. R1 further stated the staff don't hear them and never come as she pointed to the jingle bells the surveyor had picked up off the floor. R1 further stated it is "self-defeating when they don't answer you". R3's quarterly MDS 6/9/22, identified R3 had diagnoses of renal disease and diabetes, R3 had moderate cognitive impairment, was a high fall risk, chocking risk, and received anticoagulant medication (blood thinner). The MDS also indicated R3 required extensive assist from two or more staff for bed mobility, toileting, and transfers. During an observation and interview on 8/9/2022, at 12:50 p.m., R3 stated the call light system has not worked in over a week and that he couldn't do anything for himself. Further stated he was given a set of "jingle bells" but they had fallen on the floor and his door was shut so they [staff] couldn't hear him holler. He stated no one checked on him between the hours of 8:45 p.m. and 3:15 a.m. and had to wet himself because he could not get help to use the bathroom. R3 stated he preferred to eat in his room.	F 689	staff and housekeeping on the new call light system. Call light system will be audited by nursing staff daily for four weeks, then as needed to ensure it is in working order. Any issues in the system will be immediately brought to the Director of ES and Executive Director, who will then call the provider for repair. Any issues found will be brought to QAPI.	

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F 689	Continued From page 4 R5's quarterly MDS dated 7/27/22, identified R5 had diagnosis of asthma/lung diseases, R5's cognition was not assessed, R5 was a fall risk, incontinent of bowel/bladder, and totally dependent on two or more staff for bed mobility, toileting and personal hygiene. The MDS also identified R5 received diuretic medication(s). During observation and interview on 8/9/2022, at 2:35 p.m., R5 had a cow bell on her table. R5 stated she has been using the cow bell for 2 ½ weeks but was not sure if the staff heard it because it took so long for them to answer. R5 indicated she needed assistance with transfers and toileting. Further stated sometimes she "really needs to go to the bathroom and if you are incontinent, you feel bad, they [staff] aren't happy, no one is happy". R5 also indicated she has been told not to ring the call bell so long but, "I am not even sure if they can hear it because it takes them so long". R6's admission MDS dated 7/7/22, identified R6 had diagnoses of diabetes, hip fracture, and had cataracts/glaucoma. The MDS also indicated R6 did not have cognitive impairment, had bowel/bladder incontinence, moisture associated skin damage, a surgical wound, and required oxygen. R3 was totally dependent on two or more staff for bed mobility, transfers, personal hygiene, and toileting. During observation and interview on 8/9/2022, at 3:08 p.m., R6 stated the call lights have been out for more than a week. Further stated it takes some time for the staff to respond and her neighbor did not like her using her hand bell so she will call out, "yoo-hoo" until someone hears	F 689		

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F 689	Continued From page 5 her. R2's quarterly MDS dated 7/7/11, identified R2 had diagnoses of paraplegia, seizure disorder, respiratory failure and respiratory disease, and had a stage 3 pressure ulcer. The MDS indicated R2 did not have cognitive impairment and was totally dependent on two or more staff for bed mobility, transfers and toileting. During observation and interview on 8/9/2022, at 3:55 p.m., R2 indicated the call light system had been out, the facility staff had given him a hand bell to use. R2 further indicated he did not have use of his arms so could not use a hand bell, would have to holler or use his voice activated cell phone or media device to call the nurse's station for assistance, and had to call several times to get someone to answer the phone. R2 further indicated the facility was supposed to do 15-minute checks but they were not getting done. R2 stated his door was shut at night and staff did not open the door to check on him. R7's quarterly MDS dated 5/17/22, identified primary medical condition of debility, cardio-respiratory conditions with additional diagnoses of diabetes and anxiety disorder. R7 did not have cognitive impairment, was high fall risk, required oxygen, required extensive assistance from staff for bed mobility, transfers, and toileting. During observation and interview on 8/9/2022, at 6:25 p.m., R7 stated she was "concerned about the call light system". Further stated staff gave her a bracelet with "jingle bells and no one is going to hear me with that". Then staff gave her a call bell "I have to ring the heck out of it" and if	F 689		

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F 689	Continued From page 6 someone else was hollering like they really needed help, she would call the nurse's station for them with her personal cell phone. R7 indicated staff were supposed to be doing 15-minutes checks but it was done "sometimes, but not always" and further indicated that she was incontinent but has had to sit in a wet brief for extended periods of time. R8's quarterly MDS dated 7/9/22, identified R8 had diagnoses of Alzheimer's disease and unstageable pressure ulcer. R8 had severely impaired cognition and was totally dependent on staff for transfers, eating, toilet use and personal hygiene. During an observation on 8/10/2022, at 9:24 a.m., R8 was observed in her chair with a call light system cord clipped to the bear sitting on her lap; when it was attempted to activate the call light, there was not a visible or audible alert to notify the nursing staff. R8 did not have any other visible call bell within her reach. R9's annual MDS dated 8/4/22 identified R9's primary medical condition of debility, cardiovascular condition with additional diagnoses of seizure disorder, and respiratory failure. R9 had moderate cognitive impairment, incontinent of bowel/bladder and was totally dependent on two or more staff for toileting and transfers. During an observation on 8/10/2022, at 9:26 a.m. R9 was observed sitting in a wheelchair in her room. No call bell was noted within her reach. During an observation on 8/10/2022, At 9:28 a.m., R1 was observed in her wheelchair with a	F 689		

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F 689	Continued From page 7 call light system cord clipped to the back of her right shoulder with a zip tie of jingle bells attached to it. R1 did not have use of her left arm so was unable to reach it, she stated she couldn't see it attached to her back. R11's admission MDS dated 5/19/22, identified R11 had diagnoses diabetes, anxiety disorder, and had an unstageable and stage 2 pressure ulcer. R11 did not have cognitive impairment and R11 required extensive assist of two or more staff for bed mobility, transfers, and toileting. During observation and interview on 8/10/ 2022 at 9:50 a.m., R11 stated he was concerned about the call light system not working for almost a month. Indicated he was given a zip tie with jingle bells on it "like they give kids" and it kept falling on the floor so he would have to holler for help. Further stated, "I am vulnerable and need help, it is an uneasy feeling when you do not have a call light to call for help when you need it." Staff brought him a bike horn that morning but, he stated, "I had to promise I wouldn't abuse it". R11 further indicated he heard others hollering, "it makes me nervous; it has been going on for a month". R1, R3, R5, R6, R2, R7, R8, R9, and R11's records did not include functional and/or cognitive assessments to determine their ability to use the alternative staff communication system nor evidence of individualized safety plans that would address the resident's vulnerabilities. During an interview on 8/9/2022, at 4:12 p.m., DON-A indicated the call light system had been down since July 24th , we obtained some bells from the store for the residents, and staff were	F 689		

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F 689	Continued From page 8 doing 15-minute checks. DON-A did not know where the 15-minute check logs were and could not confirm they were being done. DON-A stated, "it is hard for us to make sure it is getting done". Further indicated the nursing staff were expected to do 15-minute checks in addition to their regular duties, had not added any additional staff, and administration had not been assisting with the checks. DON-A stated we want to add two more staff than we usually have, but census was low, so we could not. During a follow up interview on 8/10/2022, at 1:05 p.m., DON-A indicated individualized assessments of resident needs and vulnerabilities were not completed and safety plans were not individualized, stated "just bells and 15-minute checks for everyone". DON-A verified there was not increased supervision for residents at high risk for falls or accidents. During interview on 8/9/2022, at 4:30 p.m., DON-B indicated the 15-minute check log sheets were not consistently completed and many were missing. Further indicated she did not know if the staff were completing the 15-minute checks as expected. During an interview on 8/9/2022, at 4:33 p.m., the maintenance supervisor stated approximately four weeks ago the 200 wing call light system was "shorting out and the beeper was going off non-stop so disconnected the beeper." He further stated, approximately three weeks ago the entire call light system went out and will need an entirely new system. He stated he was concerned about it and had obtained bids, but it was "a lot of money and the owner needs to give his approval". He indicated available hand bells were handed out to the residents but is not effective and getting the approval for the call light	F 689		

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F 689	Continued From page 9 system replacement was taking longer than expected. During an interview on 8/10/2022, at 12:00 p.m., the assistant administrator indicated she was not sure when the call light system went out but thought it was Sunday, July 31st. Further indicated they created 15-minute check logs which was given to the nursing department to manage it and was discussed it at morning meeting. They bought louder bells at Michael's craft store on 8/9/2022. During an interview on 8/10/2022, at 1:24 p.m., certified nursing assistant (CNA)-A stated the residents must ring the manual call bells for a long time before we can hear it. CNA-A further indicated 15-minute checks were difficult, especially on the weekends when there were only two CNAs to cover all the residents; administration did not help with the 15-minute checks. During an interview on 8/10/2022, at 1:35 p.m., CNA-B stated staff could not hear the manual call bells at the end of the halls. Further indicated there was not enough staff to do the 15-minute checks. During an interview on 8/10/2022, at 1:45 p.m., the social service director (SSD) indicated she also had concerns about the call light system being down; many of the residents did not have the strength to ring loud enough to make the noise needed to be heard by staff. The SSD further indicated she did not know if the resident's needs were being met or not but, some residents had complained about the lack of a working call light system.	F 689		

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F 689	Continued From page 10 During an interview on 8/10/2022, at 2:38 p.m., RN-C stated the jingle bells were "faint" and not easily heard. Further indicated she didn't feel the manual call bells were effective and resident needs were not getting met. RN-C stated there was enough staff to meet the resident basic needs but not enough to effectively do 15-minute safety checks since the call light system went out. During an interview on 8/10/2022, at 3:55 p.m., the therapy director stated many of the residents did not have the upper body strength to shake a manual bell for an extended amount of time or cognitively able to learn a different system of calling for help. She further indicated a call light system was universal and ingrained that when you push a button, it stays on, many don't understand they have to continue to ring until someone comes. Stated residents were asking for less assistance and they had voiced hesitancy to ring their bell as not to disturb their roommates. Stated she received an email on July 25th indicating the door alarms on the emergency exits were not working and to keep an eye on the residents who were exit seeking. Did not recall there being a safety plan in place for those residents or being notified that the door alarms were fixed and working. Therapy director stated knowledge of the 15-minute checks for safety but that it was delegated to the nursing staff but there was not enough nursing staff to do the 15-minute safety checks. Stated resident acuity was high and staffing was based on the number of residents, not acuity. During an interview on 8/10/2022, at 5:24 p.m., the maintenance supervisor indicated two of the exit door alarms were affected by the call light	F 689		

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F 689	Continued From page 11 system outage and temporary alarms were installed on July 28th (four days after the call light system failure). He further indicated he notified nursing that the doors were not locking or alarming as a female resident who was no longer there was exit-seeking at that time. During an interview on 8/11/2022 at 10:44 a.m., the Administrator stated the call light system bids have been submitted to insurance and he was working with the owners. Further stated within an "adequate" time we will have a call light system installed. No further information was provided. According to an emailed letter received by the surveyor on 8/16/2022, DON-B indicated the facility leadership did not instruct staff to do 15-minute safety checks until six days after the call light system malfunctioned. Also indicated call light system had not been quoted until after surveyor exited. There was no written safety plan provided to the surveyor to ensure the safety of the residents during the call light system and emergency exit outage. A Call Light Policy was requested but not supplied. The IJ was removed after verification the facility had implemented the following: -A contingency plan in the event a call light failure was developed and implemented. -All residents were assessed for the implementation of a temporary nurse call system. Residents who were unable to use the call system were provided with frequent monitoring to ensure their needs were met. The care plans	F 689		

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F 689	Continued From page 12 were revised. -The facility purchased a replacement resident call system. -Staff were provided with education on the contingency plan policy and plan.	F 689		
F 839 SS=F	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure two of eight facility employed professional nursing staff (DON-A and LPN-A) reviewed were currently licensed to practice nursing within the State. This had potential to affect all 40 residents living in the facility. Findings included: Director of Nursing (DON)-A's employee record was reviewed. The record indicated DON-A was hired as the DON of the facility on 10/28/2021. This surveyor was provided a photocopy of a Minnesota Board of Nursing (MBN) license for DON-A, that did not include birth year and inconsistent fonts. When the surveyor attempted to verify the photocopy of the printout, found the license not to be factual and MBN had no record	F 839	Staff Qualifications - License verification (monthly indefinitely) Revision of policy and procedure 1. Upon being notified that the DON (DON-A) was not qualified, the DON was immediately dismissed. Additionally, the named nurse (LPN-A) was also placed on administrative leave until the proper license is renewed. Professional license is looked up upon offer of position with the facility. Staff hired by corporate office will have license looked up at the facility level by the Director of HR and/or Executive Director. Licenses are printed and added to HR file and binder. 2. All residents have the potential to be	9/3/22

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F 839	Continued From page 13 DON-A had a current registered nurse license in the state of MN. Licensed practical nurse (LPN)-A's employee record was reviewed. The record indicated an original hire date of 6/6/2014. The MBN license verification indicated LPN-A's license expired on 11/30/2020. LPN-A provided cares for the residents with an expired license between 12/1/2020 to 8/15/2022. During an interview on 8/15/2022, at 2:00 p.m. DON-B indicated that after looking at the MBN license verification website, DON-A was not registered to practice nursing in Minnesota and was not sure where the copied license verification that was provided to the surveyor came from. DON-B also verified LPN-A license expired as of 11/30/2020 and LPN-A was working that day but would be sent home immediately. DON-B further stated she was hired as the DON and began her employment one day prior to survey. Stated she was not aware of the facility process of checking professional licenses yet. DON-B indicated the copied license verification provided to the surveyor did not look authentic. During an interview on 8/15/2022, at 2:30 p.m., LPN-A stated she had been late renewing but provided an email confirmation of payment to the MBN on 12/3/2020. LPN-A stated that her licensed was expired as of 11/30/2020 according to the MBN license verification website. During an interview on 8/15/2022, at 2:50 p.m., via phone, DON-A stated she was on the registry but could not verify her license number and further stated she did not know who provided the surveyor with a copy of her license verification.	F 839	affected by this type of situation. An Excel spreadsheet has been created for all professional staff that are licensed. 3. All professional licenses are audited for validation. Current check of all licenses is done and an email sent to all license holders reminding them of expiration date, even if it is a year or more away. The first week of each month, a license check will be completed by the Director of HR or designee, a copy printed and added to binder. An email will be sent to staff member 1 month prior to expiration of license. This email is printed and put in HR file. Director of HR or designee will add a calendar reminder to check license one week before the expiration date and if it has not been updated remind the staff member if their license expires, they will be removed from the floor until such time that the license is in good standing. 4. Executive Director or designee will conduct audits to ensure process is being completed. Audits will be conducted weekly for four weeks, then as needed. Any issues found will be brought to QAPI.	

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F 839	Continued From page 14 DON-A stated she would contact this surveyor with confirmation of her MBN license number but no further follow up information was provided. During an interview on 8/15/2022, at 3:25 p.m., the assistant administrator with human resource responsibilities stated they are "supposed to do monthly professional license checks" which would include LPN-A and DON-A. Further stated she knew that LPN-A's nursing license was expired but couldn't recall when she became aware. Further stated she had questioned LPN-A but was assured it was taken care of and stated, "I trust her so did not verify" allowing LPN-A to continue working a full time status. Stated she did the new hire onboarding paperwork for DON-A but did not verify that DON-A held a Minnesota nursing license. Facility policy was not provided.	F 839		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to ensure an adequate centralized communication system to allow for residents to call for staff assistance. This affected 8 of 8 residents reviewed (R3, R1,	F 919	F919 – Resident Call System 1. Residents that were identified as incapable of using bells in the interim were put on 15-minute checks to ensure	9/3/22

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F 919	Continued From page 15 R5, R6, R2, R8, R9, and R11) in addition to all other residents (31) that resided in the facility. Findings include: Concerns were submitted to the state agency dated 8/1/2022 and 8/2/2022, which indicated the facility did not have a call light system in place and the resident's needs were not being met. During an observation and interview on 8/9/2022, at 12:50 p.m., R3 stated the call light system hasn't worked in over a week and that he couldn't do anything for himself. Further stated he was given a set of "jingle bells" but they had fallen on the floor and his door was shut so they couldn't hear him holler. He stated no one checked on him between the hours of 8:45 p.m. and 3:15 a.m. and had to wet himself because he couldn't get help to use the bathroom. During observation and interview on 8/9/2022 at 2:10 p.m., R1 stated her call light didn't work. Observed a ring of 8 jingle bells on the floor next to R1's wheelchair. R1 further stated the staff don't hear them and never come as she pointed to the jingle bells the surveyor had picked up off the floor. R1 further stated it is "self-defeating when they don't answer you". During observation and interview on 8/9/2022, at 2:35 p.m., R5 had a cow bell on her table. R5 stated she has been using the cow bell for 2 ½ weeks but wasn't sure if the staff heard it because it took so long for them to answer. During observation and interview on 8/9/2022, at 3:08 p.m., R6 stated the call lights have been out for more than a week. Further stated it takes	F 919	safety. All remaining residents were instructed to utilize bells to call for assistance. This was then replaced with an interim radio call light system. Director of ES trained nurses on interim radio call light system. Nurses trained CNA's and both nurses and CNA's educated residents who have the dexterity to use the interim call light buttons. 2. All residents have the ability to be affected by this type of situation. Director of ES trained nurses on interim radio call light system. Nurses trained CNA's and both nurses and CNA's educated residents who have the dexterity to use the interim call light buttons. 3. 15-minute checks put in place right away. Excel spreadsheets created and staffing levels increased to accommodate the checks. One to two staff members per shift assigned to the checks. The leadership staff is available to assist. Vendors have been secured and a new call light system has been ordered. Install of baseplates in rooms started with projected completion date of overall system by the end of the month (9/2022). 4. Excel spreadsheet created to audit the interim call light system, to ensure that each button works. Director of ES or designee will conduct daily audits of interim call light system to ensure working order. Training of new system will be done by the Director of ES to nurse managers and leadership staff. Nurse managers will train nursing staff. Nurse managers and	

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F 919	Continued From page 16 some time for the staff to respond and her neighbor did not like her using her hand bell so she will call out, "yoohoo" until someone hears her. During observation and interview on 8/9/2022, at 3:55 p.m., R2 indicated the call light system had been and facility staff had given him a hand bell to use. R2 further indicated he did not have use of his arms so would have to holler and use his voice activated cell phone or media device to call the nurse's station for assistance however, he may have to call several times to get someone to answer the phone. During observation and interview on 8/9/2022, at 6:25 p.m., R7 stated she was "concerned about the call light system". Further stated staff gave her a bracelet with "jingle bells and no one is going to hear me with that". Then staff gave her a call bell, R7 stated, "I have to ring the heck out of it" and further stated if someone else is hollering like they really needed help, she would call the nurse's station for them with her personal cell phone. During an observation on 8/10/2022, at 9:24 a.m., R8 was observed in her chair with a call light system cord clipped to the bear sitting on her lap with no other visible call bell within her reach During an observation on 8/10/2022, at 9:26 a.m. R9 was observed sitting in a wheelchair in her room. No call bell was noted within her reach. During an observation on 8/10/2022, At 9:28 a.m., R1 was observed in her wheelchair with a call light system cord clipped to the back of her right shoulder with a zip tie of jingle bells attached	F 919	nursing staff will educate the residents on the system. Leadership team will assist with training the dietary aides, kitchen staff and housekeeping on the new call light system. Call light system will be audited by nursing staff daily for four weeks, then as needed to ensure it is in working order. Any issues in the system will be immediately brought to the Director of ES and Executive Director, who will then call the provider for repair. Any issues found will be brought to QAPI.	

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F 919	Continued From page 17 to it. R1 does not have use of her left arm so was unable to reach it and stated she couldn't see it attached to her back. During observation and interview on 8/10/ 2022 at 9:50 a.m., R11 stated he was concerned about the call light system not working for almost a month. Further stated, "it is an uneasy feeling when you don't have a call light to call for help when you need it." Staff brought him a bike horn that morning but, he stated, "I had to promise I wouldn't abuse it". Indicated he would have to holler loudly when he needed help because he was at the end of the hallway and that he heard a lot of other residents hollering. During interview 8/9/2022, at 4:18 p.m., DON-A stated the call light system has not worked since July 24th and it needs to be replaced but it is expensive to replace. During an interview on 8/9/2022, at 4:33 p.m., the maintenance director stated approximately four weeks ago the 200 wing was "shorting out and the beeper was going off non-stop so disconnected the beeper." He further stated, approximately three weeks ago the entire call light system went out and will need an entirely new system. He stated he was concerned about it and had obtained bids, but it was "a lot of money and the owner needs to give his approval". During an interview on 8/10/2022, at 1:24 p.m., CNA-A stated the residents must ring the manual call bells for a long time before we can hear it. During an interview on 8/10/2022, at 1:35 p.m., CNA-B stated staff cannot hear the manual call bells at the end of the halls.	F 919		

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 08/11/2022

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 919	Continued From page 18 During an interview on 8/10/2022, at 1:45 p.m., the social service director indicated she also has concerns about the call light system being down and that many of the residents don't have the strength to ring loud enough to make the noise needed to be heard by staff. During an interview on 8/10/2022, at 2:38 p.m., RN-C stated the jingle bells were "faint" and not easily heard. Further indicated she didn't feel the manual call bells were effective and resident were not getting their needs met. During an interview on 8/10/2022, at 3:55 p.m., the director of therapy stated many of the residents don't have the upper body strength to shake a manual bell or cognitively able to learn a different system of calling for help. She further indicated a call light system is universal and ingrained that you push a button, and it stays on, many don't understand they have to continue to ring until someone comes. During an interview on 8/11/2022 at 10:44 a.m., the Administrator stated the call light system bids have been submitted to insurance and he was working with the owners. Further stated within an "adequate" time we will have a call light system installed. Administrator did not provide the bids nor the date of submission to the insurance provider. A Call Light Policy was requested but not supplied.	F 919		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)	F 925		9/3/22

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F 925	Continued From page 19 §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an effective pest control program to control flies in the building for 7 of 7 residents (R5, R2, R12, R7, R13, R14, R8) which also had the potential to affect all 40 residents who resided in the facility. Findings include: During observation and interview on 8/9/2022, at 2:35 p.m., R5 was observed sitting in her wheelchair with multiple flies flying around her face and tray table. R5 requested surveyor get her a flyswatter and stated, "they [flies] are terrible here". During observation and interview on 8/9/2022, at 3:55 p.m., R2 was observed in room with three flies visible landing on his personal items. R5 stated the flies were "bad", they are landing on people's food, and are in the kitchen. During interview on 8/9/2022, at 4:27 p.m., R12 stated, "the flies are horrible in this place, my room is full of them". During observation on 8/9/2022, at 6:25 p.m., R7 was observed swatting a fly on her tray table with a flyswatter. During dining observation on 8/9/2022, at 5:33 p.m., six residents sitting at one table were being fed by staff. Multiple flies were observed on that table, on the resident's food, and residents	F 925	F925 – Maintain Effective Pest Control Program 1. All residents identified were immediately relocated to a different area in the building to be away from infested area. Leadership team given fly swatters to attempt to exterminate the current pests. New pest control company has been hired, Ecolab Inc., contracted for 1x a month and outside treatment is contracted for 2x a year. Ecolab can be called by maintenance if need arises. 2. All residents have the ability to be affected by this type of situation. New 15 UV bug lights with sticky paper inside have been installed in the facility. 3. New 15 UV bug lights with sticky paper inside have been installed in the facility. Auditing of bug lights to make sure they are working, 1x a week for four weeks and 1x biweekly for one month and 1x a month indefinitely. New pest control company has been hired, Ecolab Inc., contracted for 1x a month and outside treatment is contracted for 2x a year. Ecolab can be called by maintenance if need arises. 4. Director of ES or designee will be auditing bug lights to make sure they are working, 1x a week for four weeks and 1x	

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F 925	Continued From page 20 clothing. R13 observed sitting alone at a table with a fly on his shoulder and four on the table next to his plate. Flies appeared were excessive throughout the dining room. An unidentified male certified nursing assistant (CNA) was observed feeding residents and indicated there "is always a lot of flies". During observation on 8/10/2022, at 9:30 a.m., R14's bed was observed unmade with three flies on the bed protection pad. During interview on 8/10/2022, at 11:10 a.m., family member (FM)-A stated the facility "has a problem with flies, they were horrible when I was visiting yesterday". During dining observation on 8/10/22, at 11:46 a.m., R8 was being assisted with eating and flies were noted on the top of R8's apple juice glass and on the whip cream on her dessert. Flies observed on multiple occupied tables. During an interview on 8/10/2022, at 12:00 p.m. the administrator assistant indicated the flies are challenging but we have initiated an entry way bug zapper, bought more flyswatter for staff to use, clean the patio area once a week, and remind the CNAs to clean up resident rooms and empty the garbage. Also indicated pest control has been contacted to spray the outside. During an interview on 8/10/2022, at 1:05 p.m., DON-A indicated the flies are excessive and had sent emails but told that was what to expect in Minnesota. During an interview on 8/10/2022, at 1:24 p.m., CNA-A indicated the flies are bad like this every	F 925	biweekly for one month and 1x a month indefinitely. Director of ES will be Interviewing (3) random residents, 1x a week for four weeks and 1x biweekly for one month and monthly at residents counsel indefinitely to ensure satisfaction with new pest control program.	

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F 925	Continued From page 21 year and nothing gets done about it. During an interview on 8/10/2022, at 1:50 p.m., the activities director indicated flies are excessive in the facility and have implemented fly traps for the patio, flyswatters, and spray down the patio weekly but, they are still excessive. During an interview on 8/10/2022, at 2:40 p.m., RN-C stated, "everyone is sick of the flies, they are everywhere in the community". During an interview on 8/10/2022, at 3:55 p.m., the director of therapy indicated the flies have always been a problem. Stated she has seen a resident with flies in her mouth and in her eyes. During an interview on 8/10/2022, at 5:25 p.m., the maintenance supervisor stated, "the flies are ridiculous". Further indicated pest control company was called and were expected that day to spray for the flies. A facility policy regarding pest control was requested, but none was provided.	F 925		

Electronically delivered
August 24, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: PNE711

Dear Administrator:

The above facility was surveyed on August 9, 2022 through August 11, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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
	00758	A. BUILDING: _____ B. WING _____	C 08/11/2022

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/9/2022 to 8/15/2022, 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.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53043736C (MN00085696) and H53043751C (MN00085666), . with a licensing orders issued at 0715, 1730, and 3270. The following complaint was found to be UNSUBSTANTIATED: H53043666C (MN00085697) 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 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	2 000		

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2 000	Continued From page 2 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		
2 715	MN Rule 4658.0500 Subp. 1 Director of Nursing Services; Qualifications Subpart 1. Qualifications and duties. A nursing home must have a director of nursing services who is a registered nurse. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure director of nursing (DON-A) was registered in the state of Minnesota. This had potential to affect all 40 residents living in the facility. Findings included: Director of Nursing (DON)-A's employee record was reviewed. The record indicated DON-A was hired as the DON of the facility on 10/28/2021. This surveyor was provided a photocopy of a Minnesota Board of Nursing (MBN) license for DON-A, that did not include birth year and inconsistent fonts. When the surveyor attempted to verify the photocopy of the printout, found the license not to be factual and MBN had no record DON-A had a current registered nurse license in	2 715	Corrected	9/3/22

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2 715	Continued From page 3 the state of MN. During an interview on 8/15/2022, at 2:00 p.m. DON-B indicated that after looking at the MBN license verification website, DON-A was not registered to practice nursing in Minnesota and was not sure where the copied license verification that was provided to the surveyor came from. DON-B further stated she was hired as the DON and began her employment one day prior to survey. Stated she was not aware of the facility process of checking professional licenses yet. DON-B indicated the copied license verification provided to the surveyor did not look authentic. During an interview on 8/15/2022, at 2:50 p.m., via phone, DON-A stated she was on the registry but could not verify her license number and further stated she did not know who provided the surveyor with a copy of her license verification. DON-A stated she would contact this surveyor with confirmation of her MBN license number but no further follow up information was provided. During an interview on 8/15/2022, at 3:25 p.m., the assistant administrator with human resource responsibilities stated they are "supposed to do monthly professional license checks" which would include DON-A. Stated she did the new hire onboarding paperwork for DON-A but did not verify that DON-A held a Minnesota nursing license. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for licensing verification. DON/designee could develop/implement a sustainable system to ensure staff have the current licensing/registration in the state of Minnesota.	2 715		

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2 715	Continued From page 4 The DON/designee could then develop an auditing system to ensure all nurses remain current. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 715		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement an effective pest control program to control flies in the building which had the potential to affect all 40 residents who resided in the facility. Findings include: During observation and interview on 8/9/2022, at 2:35 p.m., R5 was observed sitting in her wheelchair with multiple flies flying around her face and tray table. R5 requested surveyor get her a flyswatter and stated, "they [flies] are terrible here". During observation and interview on 8/9/2022, at 3:55 p.m., R2 was observed in room with three flies visible landing on his personal items. R5	21730	Corrected	9/3/22

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21730	Continued From page 5 stated the flies were "bad", they are landing on people's food, and are in the kitchen. During interview on 8/9/2022, at 4:27 p.m., R12 stated, "the flies are horrible in this place, my room is full of them". During observation on 8/9/2022, at 6:25 p.m., R7 was observed swatting a fly on her tray table with a flyswatter. During dining observation on 8/9/2022, at 5:33 p.m., six residents sitting at one table were being fed by staff. Multiple flies were observed on that table, on the resident's food, and residents clothing. R13 observed sitting alone at a table with a fly on his shoulder and four on the table next to his plate. Flies appeared were excessive throughout the dining room. An unidentified male certified nursing assistant (CNA) was observed feeding residents and indicated there "is always a lot of flies". During observation on 8/10/2022, at 9:30 a.m., R14's bed was observed unmade with three flies on the bed protection pad. During interview on 8/10/2022, at 11:10 a.m., family member (FM)-A stated the facility "has a problem with flies, they were horrible when I was visiting yesterday". During dining observation on 8/10/22, at 11:46 a.m., R8 was being assisted with eating and flies were noted on the top of R8's apple juice glass and on the whip cream on her dessert. Flies observed on multiple occupied tables. During an interview on 8/10/2022, at 12:00 p.m. the administrator assistant indicated the flies are	21730		

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21730	Continued From page 6 challenging but we have initiated an entry way bug zapper, bought more flyswatter for staff to use, clean the patio area once a week, and remind the CNAs to clean up resident rooms and empty the garbage. Also indicated pest control has been contacted to spray the outside. During an interview on 8/10/2022, at 1:05 p.m., DON-A indicated the flies are excessive and had sent emails but told that was what to expect in Minnesota. During an interview on 8/10/2022, at 1:24 p.m., CNA-A indicated the flies are bad like this every year and nothing gets done about it. During an interview on 8/10/2022, at 1:50 p.m., the activities director indicated flies are excessive in the facility and have implemented fly traps for the patio, flyswatters, and spray down the patio weekly but, they are still excessive. During an interview on 8/10/2022, at 2:40 p.m., RN-C stated, "everyone is sick of the flies, they are everywhere in the community". During an interview on 8/10/2022, at 3:55 p.m., the director of therapy indicated the flies have always been a problem. Stated she has seen a resident with flies in her mouth and in her eyes. During an interview on 8/10/2022, at 5:25 p.m., the maintenance supervisor stated, "the flies are ridiculous". Further indicated pest control company was called and were expected that day to spray for the flies. A facility policy regarding pest control was requested, but none was provided.	21730		

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	00758	A. BUILDING: _____ B. WING _____	C 08/11/2022

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21730	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative pest control program was developed and implemented. The facility could educate staff on these policies and perform routine environmental rounds/audits to ensure adequate pest control. The facility could report these findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21730		
23270	MN Rule 4658.5515 Nurse Call System; Existing Construction A communication system must be provided in a nursing home. It must register a call from the resident at the nursing station and activate a signal light by the bedroom door. This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to ensure an adequate centralized communication system to allow for residents to call for staff assistance. This affected 8 of 8 residents reviewed (R3, R1, R5, R6, R2, R8, R9, and R11) in addition to all other residents (31) that resided in the facility. Findings include: Concerns were submitted to the state agency dated 8/1/2022 and 8/2/2022, which indicated the	23270	Corrected	9/3/22

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23270	Continued From page 8 facility did not have a call light system in place and the resident's needs were not being met. During an observation and interview on 8/9/2022, at 12:50 p.m., R3 stated the call light system hasn't worked in over a week and that he couldn't do anything for himself. Further stated he was given a set of "jingle bells" but they had fallen on the floor and his door was shut so they couldn't hear him holler. He stated no one checked on him between the hours of 8:45 p.m. and 3:15 a.m. and had to wet himself because he couldn't get help to use the bathroom. During observation and interview on 8/9/2022 at 2:10 p.m., R1 stated her call light didn't work. Observed a ring of 8 jingle bells on the floor next to R1's wheelchair. R1 further stated the staff don't hear them and never come as she pointed to the jingle bells the surveyor had picked up off the floor. R1 further stated it is "self-defeating when they don't answer you". During observation and interview on 8/9/2022, at 2:35 p.m., R5 had a cow bell on her table. R5 stated she has been using the cow bell for 2 ½ weeks but wasn't sure if the staff heard it because it took so long for them to answer. During observation and interview on 8/9/2022, at 3:08 p.m., R6 stated the call lights have been out for more than a week. Further stated it takes some time for the staff to respond and her neighbor did not like her using her hand bell so she will call out, "yoohoo" until someone hears her. During observation and interview on 8/9/2022, at 3:55 p.m., R2 indicated the call light system had been and facility staff had given him a hand bell	23270		

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23270	Continued From page 9 to use. R2 further indicated he did not have use of his arms so would have to holler and use his voice activated cell phone or media device to call the nurse's station for assistance however, he may have to call several times to get someone to answer the phone. During observation and interview on 8/9/2022, at 6:25 p.m., R7 stated she was "concerned about the call light system". Further stated staff gave her a bracelet with "jingle bells and no one is going to hear me with that". Then staff gave her a call bell, R7 stated, "I have to ring the heck out of it" and further stated if someone else is hollering like they really needed help, she would call the nurse's station for them with her personal cell phone. During an observation on 8/10/2022, at 9:24 a.m., R8 was observed in her chair with a call light system cord clipped to the bear sitting on her lap with no other visible call bell within her reach During an observation on 8/10/2022, at 9:26 a.m. R9 was observed sitting in a wheelchair in her room. No call bell was noted within her reach. During an observation on 8/10/2022, At 9:28 a.m., R1 was observed in her wheelchair with a call light system cord clipped to the back of her right shoulder with a zip tie of jingle bells attached to it. R1 does not have use of her left arm so was unable to reach it and stated she couldn't see it attached to her back. During observation and interview on 8/10/ 2022 at 9:50 a.m., R11 stated he was concerned about the call light system not working for almost a month. Further stated, "it is an uneasy feeling when you don't have a call light to call for help	23270		

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23270	Continued From page 10 when you need it." Staff brought him a bike horn that morning but, he stated, "I had to promise I wouldn't abuse it". Indicated he would have to holler loudly when he needed help because he was at the end of the hallway and that he heard a lot of other residents hollering. During interview 8/9/2022, at 4:18 p.m., DON-A stated the call light system has not worked since July 24th and it needs to be replaced but it is expensive to replace. During an interview on 8/9/2022, at 4:33 p.m., the maintenance director stated approximately four weeks ago the 200 wing was "shorting out and the beeper was going off non-stop so disconnected the beeper." He further stated, approximately three weeks ago the entire call light system went out and will need an entirely new system. He stated he was concerned about it and had obtained bids, but it was "a lot of money and the owner needs to give his approval". During an interview on 8/10/2022, at 1:24 p.m., CNA-A stated the residents must ring the manual call bells for a long time before we can hear it. During an interview on 8/10/2022, at 1:35 p.m., CNA-B stated staff cannot hear the manual call bells at the end of the halls. During an interview on 8/10/2022, at 1:45 p.m., the social service director indicated she also has concerns about the call light system being down and that many of the residents don't have the strength to ring loud enough to make the noise needed to be heard by staff. During an interview on 8/10/2022, at 2:38 p.m., RN-C stated the jingle bells were "faint" and not	23270		

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23270	Continued From page 11 easily heard. Further indicated she didn't feel the manual call bells were effective and resident were not getting their needs met. During an interview on 8/10/2022, at 3:55 p.m., the director of therapy stated many of the residents don't have the upper body strength to shake a manual bell or cognitively able to learn a different system of calling for help. She further indicated a call light system is universal and ingrained that you push a button, and it stays on, many don't understand they have to continue to ring until someone comes. During an interview on 8/11/2022 at 10:44 a.m., the Administrator stated the call light system bids have been submitted to insurance and he was working with the owners. Further stated within an "adequate" time we will have a call light system installed. Administrator did not provide the bids nor the date of submission to the insurance provider. A Call Light Policy was requested but not supplied. SUGGESTED METHOD OF CORRECTION: The administrator/designee could review/revise nurse call system policy/procedures. Administrator/designee could purchase new call system and ensure all staff and residents are trained on using. The facility could further ensure contingency plan and equipment are available in the event of any subsequent outages. The administrator/designee could then develop and implement an auditing system as part of the	23270		

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23270	Continued From page 12 facility's quality assurance program. TIME PERIOD FOR CORRECTION: Twenty One (21) days	23270		