Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL267307705M
Compliance #: HL267304522C

Date Concluded: April 15, 2024

Name, Address, and County of Licensee Investigated:
Cannon Falls Assisted Living
900 Main Street W
Cannon Falls, MN 55009
Goodhue County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The resident was neglected when the facility failed to ensure the resident received care, services, and supervision according to the resident's plan of care. The resident fell and sustained multiple fractures, then laid on the floor for 6 hours before staff found her. The resident was transferred to the emergency department (ED) for evaluation and treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a fall and was not found for approximately 6 hours. Staff were following the resident individualized plan of care at the time of the incident. The resident received one safety check per shift and was seen earlier that day with no concerns.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), hospital records, facility internal

investigation, facility incident reports, staff schedules, related facility policy and procedures. The investigator observed the resident at the facility.

The resident resided in an assisted living facility with diagnoses including severe protein-calorie malnutrition, adult failure to thrive, and muscle weakness. The resident's service plan and assessment at the time of the incident indicated the resident was cognitively intact, able to make her needs known, and had no history of falls prior to the incident. The service plan and assessment indicated the resident was independent with dressing, grooming, toileting, transfers, ambulation, and medication administration. The resident's service plan included safety checks to be completed one time per shift on the day and evening shifts, with no specific time indicated. The service plan indicated the resident received meals 3 times daily.

A facility incident report indicated one day the resident had an unwitnessed fall out of bed when her feet became tangled in the blankets with injuries to her hip and wrist.

The facility investigation included a staff interview who seen and talked to the resident in the hallway just prior to the incident. The investigation indicated the resident was to have daily routine safety checks, and meal attendance documented. The investigation indicated staff documented the resident was unavailable for meals the day of the incident, which indicated they had not seen the resident.

The resident's services report documentation indicated staff frequently documented the resident was unavailable at mealtimes including breakfast and lunch. The documentation indicated the resident rarely attended meals in the dining room, as a result meal attendance was not an indicator of the resident's safety or wellbeing. On the day of the incident staff also documented the resident was unavailable for meals during the day shift. The investigation indicated the resident picked up breakfast but had not picked up her noon meal, staff became concerned, went to check on the resident and found her on the floor.

A progress note indicated unlicensed personnel (ULP) called for staff assistance in the resident's room. The resident was found lying on her stomach next to the bed. Nursing staff noted distortion of the resident's right forearm with bruising, and the resident had pain in the right hip. The note indicated 911 was called and the resident was transferred to the ED for evaluation and treatment of her injuries. Another progress note indicated after the incident occurred multiple staff were interviewed, and one staff reported seeing and talking to the resident in the hallway around 7:00 a.m. The note indicated the resident reported she fell around 7:30 a.m. but was unable to reach her pendant to call for help.

When interviewed the staff who had saw and talked to the resident the morning of the incident indicated she did not document completing the safety check on the resident because she was not working the resident's group that day.

When interviewed multiple licensed and ULP staff indicated the resident rarely went to the dining room for breakfast, and indicated it was not unusual to not see the resident at breakfast time. Staff stated the resident's safety check was not scheduled and could be completed at any time during their shift.

When interviewed the resident stated she rarely ate or ordered breakfast. The resident stated she had no concerns that staff did not respond to her or check on her as they should have.

When interviewed the resident's family member stated at the time of the incident the resident's day shift safety checks were not scheduled at a specific time. The family member stated she had no concerns staff were not providing safety checks or meals as indicated in the resident's care/service plan, and indicated she had no concerns for the resident's safety at the facility.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility staff checked on the resident, found her on the floor, and called 911 for the resident to be transported to the ED for evaluation and treatment of her injuries.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL267309045M/#HL267306632C #HL267308106M/#HL267305202C #HL267307705M/#HL267304522C On March 4, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 105 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL267309045M/#HL267306632C, tag identification 0630, 2310, and 2360. The following correction orders are issued for #HL267308106M/#HL267305202C, tag identification 0620, 0630, 1730, and 2360. The following correction order is issued for #HL267307705M/#HL267304522C, tag	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is 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. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 000	Continued From page 1 identification 0630.	0 000		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 2 knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Center (MAARC) potential concerns of maltreatment neglect for one of three residents (R2) reviewed for neglect. The facility was responsible for neglect when they failed to provide safe accurate medication administration services, and interventions as ordered for a unresponsive resident, with seizure activity,who had critically low blood sugar of 29. Although the facility had orders to administer glucagon (an emergency medication for low blood sugar) they failed to coordinate orders with hospice and implement the intervention in a timely manner,	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 3 and administered 5 times the prescribed morphine to the resident in error. The resident died. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The centers for disease control (CDC) resource dated December 30, 2022, identified severe hypoglycemia (low blood sugar) as blood sugar levels below 54 milligrams (mg)/ deciliter (dL). The CDC identified a severely low blood sugar level as a medical emergency which can lead to unconsciousness, and seizures. R2 was admitted to the facility on June 3, 2023, with diagnoses including severe protein-calorie malnutrition, adult failure to thrive, Diabetes Mellitus Type 2, hypoglycemia, and stiff person syndrome. R2's admission assessment and service plan dated June 13, 2023, indicated R2 was oriented, made her own decisions, was easily understood, and able to make her needs known. R2 required monitoring for weight loss, hands on assistance from one staff with toileting, incontinence care, dressing, mobility, and transfers. The assessment identified R2 was diagnosed with Diabetes Mellitus Type 2, and had no history of seizures. The assessment/service plan indicated the	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 4 resident received medication management services 4 times daily including administration of hypoglycemic and diabetic medications. The plan indicated R2 required diabetic management including glucometer checks, insulin administration, and coordination with the provider as needed. R2's August 2023, medication administration record MAR at the time of the incident included orders for Glucagon emergency injection kit 1 milligram (mg), with instructions to inject 1 mg/milliliter (ml) subcutaneously as needed for hypoglycemia, initiated on 6/14/2023 by Registered Nurse Director of Wellness (RNDOW)-C, with no other parameters for administration. The resident's orders also included the following: - Humulin N subcutaneous insulin (NPH) 25 units scheduled each morning at 9:00 a.m., with no parameters/instructions to hold for low blood sugar, or administer after R2 had eaten. - Glipizide ER 10 mg (an antidiabetic medication which can cause hypoglycemia) scheduled each morning at 9:00 a.m. - Novolog insulin to be given by sliding scale parameters twice daily at 8:15 a.m. and 5:00 p.m. for blood sugar readings starting at 300. - Glucose oral tablet chewable 4 gram, with instructions to give 4 tablets every hour as needed for low blood sugar, with no parameters for administration. - Morphine Sulfate oral tablet 15 mg tablet, with instructions to give 1/2 tablet (equal to 7.5 mg) every hour as needed (PRN) for pain and shortness of breath. R2's care plan at the time of the incident updated August 3, 2023, indicated R2 had a self-care deficit related to stiff person syndrome and	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 5 required assistance from one staff with dressing, mobility, transfers using a gait belt and walker/wheelchair. R2 required toileting assistance and incontinence cares, used a pendant call light to summon assistance. R2 had altered nutritional status related to failure to thrive, and received hospice end of life services related to malnutrition. R2's care plan indicated R2 received medication management services but had no specific needs identified for managing or monitoring R2 diabetes. R2's hospice plan of care and medication list dated July 13, 2023, included orders for blood glucose testing twice daily, glucose 4 gram chewable tablet, with instructions to chew 4 tablets as needed for low blood glucose 51-70, the care plan indicated R2 was prescribed insulin for management of diabetes not related to her terminal diagnosis. The hospice plan and orders did not include orders for the glucagon emergency injection for low blood glucose. On August 5, 2023, at 1:30 p.m., 4:52 p.m., and 5:05 p.m. RNDOW-C documented in R2's progress notes the resident had shortness of breath and anxiousness at 5:30 a.m. The notes indicated unlicensed personnel (ULP)-H notified hospice and the facility on-call nurse. ULP-H was instructed to administer ½ a tablet of morphine (7.5 mg), R2 went back to bed and did not eat breakfast. The note indicated R2 had low blood sugar of 105, and staff was instructed to hold R2's insulin. The progress notes indicated R2's family arrived to take R2 out of the facility, were provided with medications including as needed morphine and Ativan. The notes indicated family reported R2 began having a seizure in the car and brought R2 back to the facility. The family administered the as needed Ativan for seizure	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 6 activity to R2. The notes indicated when R2 returned to the facility around 12:00 p.m. her blood sugar level was 29, R2 was assisted into bed. The notes indicated at 12:30 p.m. R2's blood sugar had dropped to 27, and at 1:30 R2's blood sugar dropped to 24. R2's hospice orders and progress notes on August 5, 2023, indicated that morning unlicensed personnel (ULP)-H reported R2 had low blood glucose, and R2's insulin was held. The hospice record indicated the facility nurse was observed to administer Glucagon to R2 at 2:22 p.m. (2 hours and 22 minutes after being notified R2 had a critically low blood sugar). R2's August 5, 2023, medication administration record (MAR) indicated blood sugar monitoring was completed at 7:49 a.m. The MAR indicated no sliding scale insulin was indicated because R2 did not meet sliding scale parameters. The MAR indicated Glipizide ER was administered to R2 at 8:17 a.m. The MAR also indicated staff did not hold R2's insulin but rather administered R2's Humulin N subcutaneous insulin (NPH) 25 units at 8:45 a.m. The MAR included documentation that staff administered glucose oral tablet chewable 4 gram at 1:51 p.m. (about 2 hours after R2 returned with low blood sugar, unresponsive, with seizure activity). The MAR indicated the facility nurse documented administering 1 mg glucagon emergency injection kit at 2:50 p.m. (about 3 hours after R2 returned with low blood sugar, unresponsive, with seizure activity). A undated facility investigation summary indicated the morning of the incident R2's blood sugar was 105, and indicated R2's insulin was held. The summary indicated facility staff notified family R2	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 7 had received morphine that morning for being short of breath, did not eat breakfast, and had low blood sugar prior to leaving the facility. The investigation indicated camera footage reviewed by the facility showed R2 alert, interacting, and smiling at other residents as she left the facility. The investigation indicated R2's family reported the resident began having seizure activity in the car and notified the facility they were bringing R2 back. According to staff interviews R2 was unconscious, unable to hold up her head, and was having seizures when family returned R2 to the facility. R2's blood glucose was checked at 12:00 p.m. and noted to be 29. At 12:30 p.m. the hospice nurse arrived, rechecked R2's blood glucose, and noted it to be 24. The hospice nurse gave a verbal order for ULP-H to administer 4 tablets of Ativan for seizure activity X2. ULP-H dispensed the medication, and handed the crushed tablets to the hospice nurse who administered it. The hospice nurse requested the second dose of Ativan and again ULP-H dispensed the medication, and handed the crushed tablets to the hospice nurse who administered it. When ULP-H returned to the medication cart she identified she had crushed and given the hospice nurse 4 tablets of Morphine in error instead of 4 tablets of Ativan as ordered. ULP-H immediately reported the medication error to the hospice nurse who reported to the resident's provider with no indication of respiratory depression noted. The investigation indicated the hospice medical director identified concerns with management of R2's low blood glucose and indicated the Morphine medication error did not contribute to R2's death. Although the facility investigation included a statement from the RNDOW-C who stated she administered the glucagon injection at 1:30 p.m., August 5, 2023, hospice	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 8 documentation of the observed administration time indicated the glucagon injection was administered by RNDOW-C at 2:22 p.m., 2 hours and 22 minutes after R2 was reported to have a critically low blood glucose of 29. R2's narcotic log book page 32 for the morphine prescription #4326093, indicated on August 5, 2023, at 1:05 p.m. ULP-H documented administering 5 tablets, containing 7.5 mg of morphine to R2 (a total of 37.5 mg, which is 5 times the prescribed dose of morphine) not 4 tablets as identified in the facility investigation. The resident's record of death indicated the resident died on August 5, 2023, at 7:35 p.m. the day of the incident of natural causes. Other significant conditions contributing to the resident's death included Diabetes Mellitus. The facility investigation indicated on August 7, 2023, at 10:47 a.m. R2's family member emailed the facility about concerns regarding the events which occurred on R2's final day. The family arrived to the facility 10 minutes later. The investigation indicated leadership staff discussed collectively weather or not to file a report with the Minnesota Adult Abuse Reporting Center (MAARC), and it was determined that the medication error did not cause R2's death so there was no need to file a MAARC report. Although R2 had orders for a Glucagon injection for hypoglycemia prior to the incident available, facility staff did not implement the order or utilize the medication until 2:22 p.m. approximately two and a half hours after R2 returned to the facility unresponsive with seizure activity from critically low blood glucose levels. The facility investigation failed to identify R2 received 5 tablets of	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 9 morphine in error (5 times R2's prescribed dose). Although no respiratory depression was noted, the facility failed to provide safe medication administration services to R2 resulting in significant medication errors, and failed to identify R2 received 25 units of NPH insulin the morning of the incident when staff were instructed to hold the insulin for low blood glucose. Then the facility failed to implement interventions in a timely manner for treatment of R2's hypoglycemia as ordered. The facility investigation documentation indicated the family reported concerns with the care and services provided to R2 the day of her death, yet the facility determined the concerns were not reportable. On March 4, 2024, at 1:02 p.m. during and in person interview, and on March 13, 2024, at 12:58 p.m. during a phone interview ULP-H stated the day of the incident she notified the on-call nurse and hospice nurse the resident had low blood sugar and was instructed to hold the resident's insulin. ULP-H stated when R2 returned to the facility at 12:00 p.m. R2 was unresponsive, unable to swallow effectively, and indicated she had crushed the glucose tablets and tried to administer them to R2 with a syringe. ULP-H stated she reported the resident's condition and blood sugar reading in the 20's to the RNDOW-C and hospice, with no other instructions for R2's low blood sugar. ULP-H stated when the hospice nurse arrived, she instructed the ULP-H to stop trying to administer the glucose tablets because it was not safe for R2 due to decreased consciousness and seizure activity. ULP-H stated when the hospice nurse gave the verbal Ativan order it was an emergency, and she had no physical order to complete the required checks for safe medication administration at the time the medication error	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 10 occurred. ULP-H indicated she was distracted by another staff/resident at the time the med error occurred and she did not complete 6 rights for safe medication administration that that day, because there was so much going on. ULP-H stated she looked away and thought she grabbed the right medication, but when she came back to the medication cart she double checked, and noticed the error. ULP-H stated she reported the error to the nurses right away. On March 4, 2024, at 3:03 p.m. during a in person interview, and on March 14, 2024, at 4:03 p.m. during a phone interview RNDOW-C stated she was the on call nurse the day of the incident with R2. RNDOW-C stated she was notified the morning of the incident that R2 had low blood glucose and had not eaten breakfast, and instructed the ULP-H to hold R2's insulin. RNDOW-C stated she was aware the resident had low blood sugar of 29 when she arrived back to the facility unresponsive with seizure activity, but did not remember the Glucagon order at the time or check the resident's orders until after the hospice nurse mentioned something about Glucagon and R2's blood sugar continuing to drop. RNDOW-C indicated she went to the facility to check on things then left and returned later without check R2 orders for interventions for low blood sugar. RNDOW-C indicated hospice did not have R2's order for Glucagon. RNDOW-C verified the documentation in R2's MAR indicated she received insulin the morning of the incident, and indicated she was not aware of the administration. On March 15, 2024, at 10:14 a.m. a hospice Registered Nurse (RN)-N stated R2's hospice orders at the time of the incident did not include glucagon, and she was not aware the facility had	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 11 an order for R2 to receive glucagon until about two and a half hours after staff reported the resident's blood sugar was in the 20's. On March 15, 2024, at 11:47 p.m. R2's family member stated even though the facility nursing staff knew what was going on with R2, they were very absent during R2's diabetic emergency, and indicated facility staff did not respond to R2's low blood sugar timely. On March 19, 2024, via email correspondence executive director (ED)-B indicated the incident with R2 was not reportable because the resident was on hospice. The undated facility policy and procedure titled "Vulnerable Adult Maltreatment Policy" indicated the licensee would create a process to identify, prevent, and mitigated maltreatment of vulnerable adults. The policy indicated the licensee would establish guidelines for internal and external reporting of potential maltreatment of vulnerable adults. Residents, family and staff will receive required education on maltreatment as defined by Minnesota Statutes §626.5572 and how to report alleged maltreatment to the organization and to the Minnesota Adult Abuse Reporting Center (MAARC). The policy indicated any staff person who witnesses or suspected maltreatment of a vulnerable adult would report the incident immediately to their supervisor, a nurse, or the Assisted Living Director and that person will complete an incident report. If suspected abuse, neglect or financial exploitation, Director of Wellness will immediately make a report to the CEP. "Immediately" means as soon as possible, but no longer than 24 hours from the time the designee received initial knowledge that the incident occurred. If it is unclear based whether	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 620	Continued From page 12 maltreatment has occurred, and investigation into the incident will begin immediately. If within the 24 hours following the initial incident report, it is still unclear whether reportable maltreatment has occurred, a report will be made to the CEP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=J	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure individualized abuse prevention plans (IAPP) were completed and/ or individualized to ensure resident safety for 3 of 3 residents, (R1, R2, and R3), reviewed. The licensee failed to identify interventions regarding R1 using oxygen while smoking cigarettes. This resulted in serious injury when R1 had a mask on his face while smoking with his oxygen on, and started the mask on fire. R1 sustained	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 630	Continued From page 13 multiple second degree burns to his face, hands, and legs. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on September 9, 2023, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), liver cirrhosis, and liver failure. R1's admission service plan and assessment dated September 9, 2023, identified R1 was oriented and made his own decisions. The assessment identified the resident used continuous oxygen, and smoked. The assessment/service plan indicated the facility asseessment indicated staff should proceed with a smoking assessment. R1 had no smoking assessment completed. A incident report dated October 16, 2023, indicated at 9:40 a.m. R1 entered the nursing office area in his electric wheelchair yelling "help, help." Leadership staff were in the office at the time for morning stand up. R1 had visible blackened areas on his palms of both hands, thumbs, index fingers, and top of his right leg. R1 stated he was smoking with his oxygen on when the oxygen ignited which caused his burns. R1's outside medical record dated October 16,	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 630	Continued From page 14 2023 indicated the resident was transferred to the emergency department and treated for his burn injuries after smoking with oxygen at the facility. The record indicated the resident reported to medical staff he had always smoked with oxygen on for the past 8 years. The record indicated R1 sustained multiple second degree burns to his face, hands, and leg as a result of the incident. R1's care plan at the time of the incident occured identified R1 had COPD and utilized oxygen therapy for respiratory distress. The care plan indicated R1 managed his own oxygen and oxygen supplies and administered his own medication, and utilized hospice end of life services. The facility failed to assess the resident's ability to safely smoke on admission, and failed to identify R1 had unsafe smoking practices with oxygen. The care plan at the time of the incident failed to identify R1 smoked, and failed to include a plan to ensure safety for a resident who smoked and utilized oxygen. On October 17, 2023, after the incident occurred, the care plan was updated to include R1 used tobacco products independently without adaptations or supervision. The care plan indicated the resident would follow the facility smoking policy to keep himself and others safe, and instructed staff to notify nursing if R1 violated the smoking policy. The care plan indicated R1 would remove his oxygen tank from the electric wheelchair prior to going out to the designated smoking area. R1's care plan prior to October 17th, 2023, included no information regarding the residents history of smoking with oxygen and interventions to ensure R1's safety when smoking.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 630	Continued From page 15 R1's IAPP was requested,and the facility provided a section from R1's care plan which indicated R1 had a vulnerability in his mood and psychosocial well-being related to restrictions in visitation imposed by the Centers for Disease Control (CDC) for COVID-19, initiated on October 20, 2023. The document failed to indicate it was an IAPP. The facility provided document failed to identify the resident's risk to be abused, self abuse, risk to abuse others, and specific interventions to reduce those risks. The facility provided document failed to identify the resident's risk for self harm related to R1's history of smoking with oxygen. R2 was admitted to the facility on June 3, 2023, with diagnoses including severe protein-calorie malnutrition, adult failure to thrive, Diabetes Mellitus Type 2, hypoglycemia, and stiff person syndrome. R2's admission assessment and service plan dated June 13, 2023, indicated R2 was oriented and made her own decisions, was easily understood and able to make her needs known. R2 required monitoring for weight loss, hands on assistance from one staff with toileting, incontinence care, dressing, mobility, and transfers. The assessment identified R2 was diagnosed with Diabetes Mellitus Type 2, and had no history of seizures. The resident received medication management services including administration of hypoglycemic and diabetic medications. R2's medication management assessment plan indicated R2 would receive medication management services 4 times daily. The plan indicated R2 required diabetic management including glucometer checks, insulin administration, and coordination with the provider as needed.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 630	Continued From page 16 R2's care plan dated June 13, 2023, indicated R2 had a self-care deficit and required assistance from one staff with dressing, mobility, transfers using a gait belt and walker/wheelchair. R2 required toileting assistance and incontinence cares and used a pendant call light to summon assistance. R2 had altered nutritional status related to failure to thrive, and received hospice end of life services related to malnutrition. R2's IAPP was requested, none was provided. R3 was admitted to the facility on November 1, 2022, with diagnoses including severe protein-calorie malnutrition, adult failure to thrive, and muscle weakness. R3's assessment and service plan dated June 7, 2023, indicated R3 was cognitively intact, her own decision maker, easily understood, and able to make her needs known. R3 was independent with dressing, grooming, transfers, and mobility using a walker. R3 used a pendant call light to ring for assistance if needed, and had no history of falls. R3 self administered her own medications. R3's IAPP was requested and the facility provided a document implemented on October 25, 2023, that appeared to be a section from R3's care plan titled "vulnerability". The document indicated R3 had a vulnerability to self and others related to unsteady gait. The document indicated R3 would remain safe with her 4 wheeled walker, and indicated staff would keep the environment free from hazards. The document failed to identify R3's risk for abuse, risk to abuse others, self abuse, or provide specific interventions to reduce those risks.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 630	Continued From page 17 On March 6, 2024, at 11:23 a.m. Executive Director (ED)-B emailed and verified R1 did not have a smoking assessment, or signed smoking policy to ensure the residents safety completed prior to the incident. On March 6, 2024, at 2:03 p.m. an email correspondence from ED-B indicated the provided documented for R1 and R3 were the resident's IAPP's and R2 did not have an IAPP completed. . During interview on March 14, 2024, at 4:03 p.m. Registered Nurse, Director of Wellness (RNDOW)-C stated an IAPP was a separate assessment to determine each resident's risk for abuse, and each resident should have one completed in their care plan, specific to their needs completed under vulnerability section. No IAPP assessment was provided for any of the resident's reviewed. The undated facility policy and procedure titled "Individual Abuse Prevention Plan" indicated the facility would develop and implement and individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are considered vulnerable adults. The policy and procedure indicated the IAPP would contain and individualized review/assessment of the resident's susceptibility to abuse by another individual including other vulnerable adults, the persons risk of abusing other vulnerable adults, risk for self abuse, and statements of specific measures taken to reduce the risk of abuse to that person and other vulnerable adults. No further information provided.	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
0 630	Continued From page 18 TIME PERIOD FOR CORRECTION: Two (2) days.	0 630		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed assessments after the resident had changes in her health condition for one of one residents, (R2) with records reviewed.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01620	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's admission assessment and service plan, dated June 14, 2023, indicated the resident received services including medication administration, assistance with dressing, grooming, bathing, mobility, and transfers. A progress note dated July 11, 2023, indicated R2 was admitted to the hospital for a urinary tract infection and low sodium. On July 13, 2023, a progress note indicated the resident returned to the facility and was admitted to hospice. R2 had no change in condition assessment following hospitalization and subsequent hospice admission. During interview on March 4, 2024, at 3:03 p.m. and March 14, 2024, at 4:03 p.m. Registered Nurse Director of Wellness (RNDOW)-C stated there was no process to ensure a change of condition assessment was completed when a resident was admitted to hospice services. On March 14, 2024, at 1:30 p.m. the executive director (ED)-B verified by email no change of condition assessment was completed after R2's	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01620	Continued From page 20 hospitalization and subsequent admission to hospice on July 13, 2023. The undated licensee's policy and procedure titled "Assessment , Reviews, and Monitoring" indicated the RN would conduct a nursing assessment of the perspective resident;s physical and cognitive needs. Section 3. indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. Section 5. a. indicated an initial review would be completed within 30 calendar days of the start of services. section d. indicated resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. Section 6. indicated the facility will conduct a nursing assessment during a holiday, and the weekend for a resident who is ready to be discharged from the hospital and return to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	01620		
01730 SS=G	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 21 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 22 licensee failed to develop an individualized medication management plan with the required content for one of one resident's (R2) receiving medication management services with records reviewed. The licensee failed to provide safe accurate medication administration services and administered insulin when R2 had low blood sugar and had not eaten. R2 became unresponsive, with seizure activity, and had a critically low blood sugar of 29. Although the facility had orders to administer glucagon (an emergency medication for low blood sugar) they failed to coordinate orders with hospice and did not administered glucagon for over two hours. R2 remained unresponsive until her death approximately 7.5 hours after the first low critically low blood glucose reading. This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The centers for disease control (CDC) internet resource dated December 30, 2022, identified severe hypoglycemia (low blood sugar) as blood sugar levels below 54 milligrams (mg)/ deciliter (dL). The CDC identified a severely low blood sugar level as a medical emergency which can lead to unconsciousness, and seizures. R2 was admitted to the licensee on on June 3, 2023, with diagnoses including severe	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 23 protein-calorie malnutrition, adult failure to thrive, Diabetes Mellitus Type 2, and hypoglycemia. R2's admission assessment and service plan dated June 13, 2023, indicated R2 was oriented, made her own decisions, was easily understood, and able to make her needs known. R2 required monitoring for weight loss, hands on assistance from one staff with toileting, incontinence care, dressing, mobility, and transfers. The assessment identified R2 was diagnosed with Diabetes Mellitus Type 2, and had no history of seizures. The assessment/service plan indicated the resident received medication management services including administration of hypoglycemic and diabetic medications. R2's Individualized Medication Management Plan dated June 14, 2023, completed by Registered Nurse Director of Wellness (RNDOW)-C indicated R2 would receive medication management services 4 times daily. The plan indicated R2 required diabetic management including glucometer checks, hypoglycemic and diabetic medications, and coordination with the provider as needed. R2's medication management plan lacked evidence of: (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 24 on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. R2's care plan at the time of the incident indicated R2 had a self-care deficit related to stiff person syndrome and required assistance from one staff with dressing, mobility, transfers using a gait belt and walker/wheelchair. R2 required toileting assistance and incontinence cares, used a pendant call light to summon assistance. R2 had altered nutritional status related to failure to thrive, and received hospice end of life services related to malnutrition. R2's care plan indicated R2 received medication management services but had no specific needs identified for managing	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 25 or monitoring R2 diabetes including possible adverse medication side effects, and symptoms of hypo/hyperglycemia, when to notify the nurse, or instructions for staff to know how and when to implement prescribed interventions (glucose tablets and glucagon injection) in the event R2 had low blood sugar. R2's August 2023, medication administration record MAR at the time of the incident included orders for Glucagon emergency injection kit 1 milligram (mg), with instructions to inject 1 mg/milliliter (ml) subcutaneously as needed for hypoglycemia, initiated on 6/14/2023 by Registered Nurse Director of Wellness (RNDOW)-C, with no other parameters for administration. The resident's orders also included the following: - Humulin N subcutaneous insulin (NPH) 25 units scheduled each morning at 9:00 a.m., with no parameters/instructions to hold for low blood sugar, or administer after R2 had eaten. - Glipizide ER 10 mg (an antidiabetic medication which can cause hypoglycemia) scheduled each morning at 9:00 a.m. - Novolog insulin to be given by sliding scale parameters twice daily at 8:15 a.m. and 5:00 p.m. for blood sugar readings starting at 300. - Glucose oral tablet chewable 4 gram, with instructions to give 4 tablets every hour as needed for low blood sugar, with no parameters for administration. - Morphine Sulfate oral tablet 15 mg tablet, with instructions to give 1/2 tablet (equal to 7.5 mg) every hour as needed (PRN) for pain and shortness of breath. R2's care plan updated August 3, 2023, indicated R2 had failure to thrive and received hospice end of life services related to malnutrition. The care	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 26 plan identified R2 received medication management services but failed to provide specific interventions to manage R2 diabetes to include symptoms and monitoring for a resident with hypoglycemia, and directions/parameters for implementation of interventions and monitoring for hypoglycemia to include prescribed oral glucose and Glucagon injection. R2's hospice plan of care and medication list dated July 13, 2023, included orders for blood glucose testing twice daily, glucose 4 gram chewable tablet, with instructions to chew 4 tablets as needed for low blood glucose 51-70, the care plan indicated R2 was prescribed insulin for management of diabetes not related to her terminal diagnosis. The hospice plan and orders did not include orders for the Glucagon emergency injection for low blood glucose. On August 5, 2023, at 1:30 p.m., 4:52 p.m., and 5:05 p.m. RNDOW-C documented in R2's progress notes the resident had shortness of breath and anxiousness at 5:30 a.m. The notes indicated unlicensed personnel (ULP)-H notified hospice and the facility on-call nurse. ULP-H was instructed to administer ½ a tablet of morphine (7.5 mg), R2 went back to bed and did not eat breakfast. The note indicated R2 had low blood sugar of 105, and staff was instructed to hold R2's insulin. The progress notes indicated R2's family arrived to take R2 out of the facility and family were provided with R2's medications including as needed morphine and Ativan. The notes indicated family reported R2 began having a seizure in the car and brought R2 back to the facility. The family administered the as needed Ativan for seizure activity to R2. The notes indicated when R2 returned to the facility around 12:00 p.m. her blood sugar level was 29, R2 was	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 27 assisted into bed. The notes indicated at 12:30 p.m. R2's blood sugar had dropped to 27, and at 1:30 p.m., R2's blood sugar dropped to 24. R2's hospice orders and progress notes on August 5, 2023, indicated earlier that morning unlicensed personnel (ULP)-H reported R2 had low blood glucose, and R2's insulin was held. The hospice record indicated the facility nurse was observed administering Glucagon to R2 at 2:22 p.m. (2 hours and 22 minutes after being notified R2 had a critically low blood sugar). R2's medication administration record (MAR) dated August 5, 2023 indicated the residents blood sugar monitoring was completed at 7:49 a.m. The MAR indicated no sliding scale insulin was administered because R2 did not meet sliding scale parameters. The MAR indicated Glipizide ER (reduces blood sugar) was administered to R2 at 8:17 a.m. The MAR also indicated staff documented R2's insulin, Humulin N subcutaneous insulin (NPH), 25 units, were administered at 8:45 a.m. The MAR included documentation staff administered glucose oral tablet chewable 4 gram at 1:51 p.m. (about 2 hours after R2 returned with low blood sugar, unresponsive, with seizure activity). The MAR indicated the facility nurse documented administering 1 mg glucagon emergency injection kit at 2:50 p.m. (about 3 hours after R2 returned with low blood sugar, unresponsive, with seizure activity). On August 5, 2023, a hand written internal communication note (not part of R2's record) indicated ULP-H documented holding the resident's insulin at 8:00 a.m. The note indicated R2 returned to the facility unresponsive with a blood sugar of 29, and glucose tablets were given	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 28 but not effective. A undated facility investigation summary indicated the morning of the incident R2's blood sugar was 105, and indicated R2's insulin was held. The summary indicated facility staff notified family R2 had received morphine that morning for being short of breath, did not eat breakfast, and had low blood sugar prior to leaving the facility. The investigation indicated camera footage reviewed by the facility showed R2 alert, interacting, and smiling at other residents as she left the facility. The investigation indicated R2's family reported the resident began having seizure activity in the car and notified the facility they were bringing R2 back. According to staff interviews R2 was unconscious, unable to hold up her head, and was having seizures when family returned R2 to the facility. R2's blood glucose was checked at 12:00 p.m. and noted to be 29. At 12:30 p.m. the hospice nurse arrived, rechecked R2's blood glucose, and noted it to be 24. The hospice nurse gave a verbal order for ULP-H to administer 4 tablets of Ativan for seizure activity X2. ULP-H dispensed the medication, and handed the crushed tablets to the hospice nurse who administered it. The hospice nurse requested the second dose of Ativan and again ULP-H dispensed the medication, and handed the crushed tablets to the hospice nurse who administered it. When ULP-H returned to the medication cart she identified she had crushed and given the hospice nurse 4 tablets of Morphine in error instead of 4 tablets of Ativan as ordered. ULP-H immediately reported the medication error to the hospice nurse who reported to the resident's provider with no indication of respiratory depression noted. The investigation indicated the hospice medical director identified concerns with management of	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 29 R2's low blood glucose and indicated the Morphine medication error did not contribute to R2's death. Although the facility investigation included a statement from the RNDOW-C who stated she administered the glucagon injection at 1:30 p.m., August 5, 2023, hospice documentation of the observed administration time indicated the glucagon injection was administered by RNDOW-C at 2:22 p.m., 2 hours and 22 minutes after the resident was reported to have a critically low blood glucose of 29. R2's narcotic log book [page 32] for the morphine prescription [#4326093], indicated on August 5, 2023, at 1:05 p.m. ULP-H documented administering 5 tablets, containing 7.5 mg of morphine to R2 (a total of 37.5 mg, which is 5 times the prescribed dose of morphine) not 4 tablets as identified in the facility investigation. Although R2 had orders for glucagon injection for hypoglycemia prior to the incident available, facility staff did not implement the order or utilize the medication until 2:22 p.m. approximately two and a half hours after R2 returned to the facility unresponsive with seizure activity from critically low blood glucose levels. The facility investigation failed to identify R2 received 5 tablets of morphine in error, although no respiratory depression was noted, the facility failed to provide safe medication administration services to R2 resulting in significant medication errors, and failed to identify R2 received 25 units of NPH insulin the morning of the incident when staff were instructed to hold the insulin for low blood glucose. Then the facility failed to implement interventions in a timely manner for treatment of R2's hypoglycemia as ordered. During interview on March 4, 2024, at 1:02 p.m.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 30 during and in person interview, and on March 13, 2024, at 12:58 p.m. during a phone interview ULP-H stated the day of the incident she notified the on-call nurse and hospice nurse R2 had low blood sugar and indicated she was instructed to hold R2's insulin. ULP-H stated when R2 returned to the facility at 12:00 p.m. R2 was unresponsive, unable to swallow effectively, and indicated she had crushed the glucose tablets and tried to administer them to R2 with a syringe. ULP-H stated she reported R2's condition and blood sugar reading in the 20's to the RNDOW-C and hospice, with no other instructions for R2's low blood sugar. ULP-H stated when the hospice nurse arrived, she instructed the ULP-H to stop trying to administer the glucose tablets R2 because it was not safe due to decreased consciousness and seizure activity. ULP-H stated when the hospice nurse gave the verbal Ativan order it was an emergency, and she had no physical order to complete the required checks for safe medication administration at the time the medication error occurred. ULP-H indicated she was distracted by another staff/resident at the time the med error occurred and she did not complete 6 rights for safe medication administration that that day, because there was so much going on. ULP-H stated she looked away and thought she grabbed the right medication, but when she came back to the medication cart she double checked, and noticed the error. ULP-H stated she reported the error to the nurses right away. On March 4, 2024, at 3:03 p.m. during a in person interview, and on March 14, 2024, at 4:03 p.m. during a phone interview RNDOW-C stated she was the on call nurse the day of the incident with R2. RNDOW-C stated she was notified the morning of the incident that R2 had low blood	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 31 glucose and had not eaten breakfast, and instructed the ULP-H to hold R2's insulin. RNDOW-C stated she was aware the resident had low blood sugar of 29 when she arrived back to the facility at 12:00 p.m. unresponsive with seizure activity, but did not remember the glucagon order at the time or check R2's orders until after the hospice nurse mentioned something about glucagon and R2's blood sugar continuing to drop. RNDOW-C indicated she went to the facility to check on things then left and returned later without checking R2's orders for interventions for low blood sugar. RNDOW-C indicated hospice did not have R2's order for glucagon. RNDOW-C verified the documentation in R2's MAR indicated she received insulin the morning of the incident, and indicated she was not aware of the administration. On March 15, 2024, at 10:14 a.m. a hospice Registered Nurse (RN)-N stated R2's hospice orders at the time of the incident did not include glucagon, and she was not aware the facility had an order for R2 to receive glucagon until about two and a half hours after staff reported the resident's blood sugar was in the 20's. On March 15, 2024, at 11:47 p.m. R2's family member stated even though the facility nursing staff knew what was going on with R2, they were very absent during R2's diabetic emergency, and indicated facility staff did not respond to R2's low blood sugar timely. The resident's record of death indicated the resident died on August 5, 2023, at 7:35 p.m. the day of the incident of natural causes. Other significant conditions contributing to the resident's death included Diabetes Mellitus.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 32 A undated licensee policy and procedure titled "Medication Management - Assessment, Monitoring, and Reassessment", indicated prior to providing medication management services, a RN, licensed health professional, or authorized prescriber would conduct an assessment to determine what medication management services would be provided and how the services will be provided. Section 1. indicated an RN would conduct a face to face assessment with the resident. 2. indicated the assessment would include identification and review of all medications the resident was known to be taking. 3. indicated the review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. 4. indicates the assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. 5. indicated the licensee would monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. A undated licensee policy and procedure titled " Medications and Treatments - PRN Medications", indicated ULP staff must be trained, and competency tested by a RN, with documentation on file. PRN medications must be administered according to the prescriber's orders. Section 1. indicated staff would review the resident's medication sheet at the time of administering medication. 2. Check the information of the	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 33 individual medication sheet for; the right person, right medication, right time, right route (i.e., by mouth, eye drop, to the skin), right dose (i.e., how many milligrams, drops), right chart/record to document that the medication was taken, 3. indicated staff would check the frequency of PRN medication if given in the last 24 hours and whether it has been given, the maximum number of times allowable for the day. 4. indicated staff would confirm whether the reasoning for giving the medication matches the reason the medication was prescribed. 5. Check the medication sheet in the medication book with the label on the medication container. The policy and procedure indicated the label should be checked three (3) times: 1) when taken from storage, 2) when removed from the container, and 3) when returned to storage. A undated licensee policy and procedure titled "Medications and Treatments - Orders - Reconciliation", indicated a RN, LPN or person qualified to receive orders will obtain all medication orders either in writing, verbally, or electronically by an authorized prescriber. Section 1. indicated all orders for medications and treatments must be dated and signed by the prescriber, and must be current and consistent with the nursing assessment. 2. indicated the medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. 3. verbal orders received from a prescriber must have the RN/LPN a. record and sign the order. b. record of the verbal order in the resident record c. forward to the prescriber for signature. A undated licensee policy and procedure titled " Medication Management - Individualized Plan", indicated the facility would prepare and include in	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 34 the service plan a written statement of the medication management services that will be provided to the resident. Section 1. indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following. a. A statement describing the medication management services that will be provided. b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. e. Identification of medication management tasks that may be delegated to unlicensed personnel. f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions 2. The medication management record will be current and updated when there are any changes. 3. Medication reconciliation will be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. The licensee policy and procedure titled "Care of a Diabetic Resident", revised August 22, 2023, following the incident with R2 indicated the licensee would assist the resident to establish a balance between diet, exercise, and insulin;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 35 prevent recurrence of hyperglycemia/hypoglycemia; recognize, assist, and document the treatment of complications commonly associated with diabetes; and individualize teaching according to carefully assessed resident and family needs. The policy indicated Diabetes Mellitus was a chronic, hereditary, or developmental disorder in which there is relative or absolute lack of insulin characterized by glucose intolerance. It is defined as Type I (Insulin-Dependent Diabetes Mellitus), and Type II (Non-Insulin-Dependent Diabetes Mellitus). The policy and procedure included early and later signs and symptoms of hyperglycemia (high blood sugar), and hypoglycemia including weakness, dizziness, or faintness, nervousness restlessness, tachycardia (increased heart rate), pale, cool, moist skin, stupor, unconsciousness and/or convulsions; and coma. Section b. indicated upon presentation of symptoms of hypoglycemia, the resident's blood glucose should be checked. A blood glucose below 70 mg/dL or a level identified per individual physician orders, hypoglycemia should be suspected. Should evidence of severe, or life threatening signs and symptoms exist contact the physician and call 911. If any of the signs symptoms of hypoglycemia or other abnormal condition was identified staff would report the diabetic resident's condition to the physician immediately. The policy procedure indicated staff should follow the residents individual hypoglycemic protocol. Section d. indicated facility protocol for hypoglycemia was to treat promptly with 15-20 grams of fast acting simple carbohydrate food for blood glucose less than 70 mg/dL and report findings to the physician. The protocol indicated licensed nursing staff should administer Glucagon 1 mg subcutaneously or intramuscularly if the resident was unable to	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
01730	Continued From page 36 ingest sugar treatment per physicians orders. Repeat the blood sugar check, and repeat the protocol once if the resident's blood sugar remains less than 70 mg/mL. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01730		
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide care in accordance with accepted healthcare standards for one of one residents (R1) reviewed. Harm occurred for R1 when the facility failed to identify R1 had unsafe smoking practices with oxygen on, R1 sustained multiple second degree burns to his face, hands, and legs. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
02310	Continued From page 37 R1 was admitted to the facility on September 9, 2023, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), liver cirrhosis, and liver failure. On September 8, 2023, at 2:31 p.m. an admission progress note indicated R1 wished to manage his own oxygen and medications. The progress note indicated during the admission assessment R1 reported he smoked occasionally and knew he should take his oxygen off before he smoked. R1's admission service plan and assessment dated September 9, 2023, identified R1 was oriented and made his own decisions. The assessment identified the resident used continuous oxygen, and smoked. The assessment/service plan indicated the facility should proceed with a smoking assessment but none was completed. A incident report dated October 16, 2023, indicated at 9:40 a.m. R1 entered the nursing office area in his electric wheelchair yelling "help, help" leadership staff were in the office at the time for morning stand up. R1 had visible blackened areas on his palms of both hands, thumbs, index fingers, and top of right leg, and reported he was smoking with his oxygen on when the oxygen ignited causing burns. R1's outside medical record indicated R1 reported to medical staff that he had always smoked with his oxygen on for the past 8 years. The record indicated R1 sustained multiple second degree burns to his face, hands, and leg as a result of the incident.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
02310	Continued From page 38 R1's care plan at the time of the incident identified R1 had COPD and utilized oxygen therapy for respiratory distress. The care plan indicated R1 managed his own oxygen and oxygen supplies and administered his own medication, and utilized hospice end of life services. The care plan at the time of the incident failed to identify R1 smoked, and failed to include a plan to ensure safety for a resident who smoked and utilized oxygen. The facility failed to assess R1's ability to safely smoke on admission, and failed to identify R1 had unsafe smoking practices with oxygen. On October 17, 2023, after the incident occurred, the care plan was updated to include R1 used tobacco products independently without adaptations or supervision. The care plan indicated R1 would follow the facility smoking policy to keep himself and others safe, and instructed staff to notify nursing if R1 violated the smoking policy. The care plan indicated R1 would remove his oxygen tank from electric wheelchair prior to going out to designated smoking area. On October 17, 2023, at 11:03 a.m. the day after the incident occurred, a progress note indicated Registered Nurse (RN)-A met with R1 and reviewed the facility smoking policy. The note indicated R1 reviewed and signed the smoking policy acknowledgment at that time. The note indicated the RN-A observed R1 smoking outside, removed his own oxygen tank and left it in his apartment prior to going to the designated smoking area. On October 17, 2023, at 12:39 p.m. a facility email communication from the RN-A to leadership staff the day after the incident indicated the RN completed a smoking assessment that day and	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
02310	Continued From page 39 educated R1 on the smoking policy. The email indicated R1 signed the smoking policy acknowledgement at that time. R1 IAPP was requested, the facility provided a section from the resident's care plan which indicated R1 had a vulnerability in his mood and psychosocial wellbeing related to restrictions in visitation imposed by the Centers for Disease Control (CDC) for COVID-19, initiated on October 20, 2023. The document failed to indicate this was an IAPP, and indicated no IAPP was completed on admisson or at the time of the incident. The facility provided document failed to identify R1's risk to be abused, self abuse, risk to abuse others, and specific interventions to reduce those risks. The facility provided document failed to identify R1's risk for self harm from R1 smoking with oxygen. A document titled "Acknowledgment of Smoking Policy" indicated R1 was advised and acknowledged/signed the facilities policy on smoking to ensure his safety and the safety of others on October 17, 2023, the day following the incident with R1. The document indicated the facility needed to complete a smoking assessment on admission, quarterly or annually as needed to evaluate the resident's ability to smoke safely and adhere to the facility smoking policy. The document included information that injury may occur if oxygen was in use while smoking. The document indicated if R1 used oxygen staff were to remove the oxygen tank prior to R1 going outside, and R1 would not smoke within 10 feet of someone using oxygen. On March 4, 2024, at 1:56 p.m. unlicensed personnel (ULP)-E stated R1 should turn off and remove before going out to smoke. ULP-E stated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
02310	Continued From page 40 R1 always had his oxygen tank on the scooter with him but did had not observed R1 smoke while using his oxygen. On March 4, 2024, at 2:21 p.m. ULP-D stated the day of the incident R1 pressed his pendant then went to the office with his scooter. ULP-D state she could smell burnt hair. ULP-D stated R1 reported he was smoking with his oxygen on, then went to blow his nose with a disposable medical mask and it caught on fire and engulfed him in flames. ULP-D stated after the incident R1 always turned his oxygen off before going out to smoke, but R1 continued to have the oxygen tanks on his scooter while smoking. On March 4, 2024, at 3:45 p.m. during an interview, leadership staff RN-A, Executive Director (ED)-B, and RNDOW-C, indicated after the incident R1 was assessed to be able to smoke independently. R1 received education on safe smoking, and was instructed to remove his oxygen before entering the designated smoking area. The leadership staff indicated after the incident R1 was informed of the smoking policy and was compliant with no ongoing safety concerns noted. On March 6, 2024, at 1:49 p.m. ULP-I stated she had observed R1 smoking with his oxygen on numerous times before and after the incident. ULP-I indicated if R1 was not wearing/using his oxygen while smoking, he had the oxygen tanks on the back of his electric wheelchair or between his legs when he smoked. ULP-I stated she had reported her concern each time to RN-A, and Registered Nurse Director of Wellness (RNDOW)-C who stated they would talk to R1. Although facility staff were aware R1 was smoking near oxygen or while wearing oxygen	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
02310	Continued From page 41 prior to the incident, they failed to ensure R1 was safe while he smoked. On March 6, 2024, at 11:23 p.m. during email correspondence ED-B verified R1 did not have a smoking assessment, or signed smoking policy to ensure R1's safety completed at the time of the incident. The licensee policy and procedure titled "Smoking and E-Cigarettes" revised on March 9, 2022, indicated smoking would only be allowed in designated outdoor area(s) that are not near flammable substances or where oxygen is in use. The policy indicated residents, resident representatives, and visitors would be informed of the facility smoking policy. The policy indicated the facility would provide education to residents for smoking on the facility property to ensure precautions are taken for the resident's individual safety as well as the safety of others in the facility. The policy indicated residents who chose to smoke would be assessed on admission, receive education about the smoking policy, and individualized approaches to ensure safety would be documented in the resident's plan of care. However, there was no indication the resident was assessed to smoke safely, education was provided, or the resident was informed of the policy to ensure his safety and the safety of others prior to the incident. The undated facility policy and procedure titled "Individual Abuse Prevention Plan" indicated the facility would develop and implement and individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are considered vulnerable adults. The policy and procedure indicated the IAPP would contain and individualized review/assessment of the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26730	A. BUILDING: _____ B. WING _____	C 03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANNON FALLS ASSISTED LIVING	900 MAIN STREET WEST 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
02310	Continued From page 42 resident's susceptibility to abuse by another individual including other vulnerable adults, the persons risk of abusing other vulnerable adults, risk for self abuse, and statements of specific measures taken to reduce the risk of abuse to that person and other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of three resident(s) reviewed (R1, and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, the facility was responsible for the maltreatment of R1, and and individual staff person was responsible for the maltreatment of R2, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		