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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DLQ0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00382

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245399**

2.STATE VENDOR OR MEDICAID NO.
(L2) **087497000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLE FALLS CARE CENTER**
(L4) **1200 FIRST AVENUE NORTHEAST**
(L5) **LITTLE FALLS, MN** (L6) **56345**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2014**

6. DATE OF SURVEY **02/20/2020** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **64** (L18)
13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Kathleen Lucas, Unit Supervisor 02/25/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 02/25/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/24/2020
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 25, 2020

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: CCN: 245399
Cycle Start Date: December 19, 2019

Dear Administrator:

On February 20, 2020, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 25, 2020

CMS Certification Number (CCN): 245399

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 12, 2020 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DLQ0

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And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room
* Code: **B*** (L12)

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17. SURVEYOR SIGNATURE Date :
Timothy Rhonemus, HFE NE II 01/29/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 02/24/2020 (L20)

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

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B. Rescind Suspension Date:
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26. TERMINATION ACTION: (L30)
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04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
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00-Active

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(L28)

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03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 8, 2020

Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: CCN: 245399
Cycle Start Date: December 19, 2019

Dear Administrator:

On December 19, 2019, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301
Email: susie.haben@state.mn.us
Phone: 320-223-7356

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 19, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 19, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted December 16-19, 2019, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/16/19 through 12/19/19, a recertification survey was conducted at your facility. Complaint investigations were also conducted. Little Falls Care Center was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5399028C H5399029C H5399031C H5399032C - deficiency issued at F677. H5399033C The following complaints were found unsubstantiated: H5399027C H5399030C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		2/12/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 2 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a homelike, dignified dining experience was provided to 3 of 3 residents (R50, R45, R48) observed to not be served with their tablemates in a timely manner. Findings include: R50's admission Minimum Data Set (MDS) dated 11/28/19, identified R50 had severe cognitive impairment and required supervision with eating. R45's quarterly MDS dated 11/14/19, identified R45 had moderate cognitive impairment and was independent with eating. Further, R48's quarterly MDS dated 11/19/19, identified R48 had intact cognition and was independent with eating. On 12/17/19, at 5:19 p.m. the supper meal was observed in the main dining room. R50, R45 and R48 were seated at a table with three other residents. At 5:36 p.m. multiple nursing assistant (NA) staff, including NA-C and NA-D, were passing plated food to the residents in the dining room at various tables. Three of the six residents seated with R45, R48 and R50 had been served and we're eating. The remaining three residents (R45, R48 and R50) were not provided any food	F 550	R50, R45 and R48 will be served with the full residents at the table. All Residents receive their beverages when they come into the dining room and are able to sit where they choose. All residents who eat in the dining rooms have the potential to be affected by a deficient practice in this area. New residents will be informed of the Kind Dining practice that we are providing. All staff are being educated on Kind Dining and the Nursing Department will have training at their 1/14/20 meetings. Culinary employees are being educated at their meetings on 1/16/20. Random Meal service Audits will be completed. One audit will be completed weekly for 4 weeks, then two audits per month for 2 months and then one audit monthly thereafter. Audits will be brought to the full quarterly QAPI meetings for review and further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 3	F 550		

and only had water and various juices to drink while others consumed their meal. After several minutes, R50 stated aloud to his other tablemates not eating, "Yep," and continued watching the three whom had been served eat their meals. At 5:46 p.m. (10 minutes later) NA-C served R48 his meal, and a moment later, R45 was served his meal and both began eating. R50 was not served his meal and continued to watch others eat. At 5:49 p.m. (13 minutes after service to the table began) R50 remained un-served and began tapping his fingers on the table simultaneously while watching his tablemates eat their meals. A moment later, at 5:50 p.m. NA-C returned to the table and served R50 his meal. When interviewed immediately following regarding the length of waiting for his meal, R50 just shrugged his shoulders and responded aloud, "I'm used to it."

During interview on 12/17/19, at 5:57 p.m. NA-D stated they had worked at the facility for a couple months and typically worked on the evening shift. NA-D expressed the tables were served in a "first come, first served" manner which had been the process since they started working at the nursing home. NA-D stated they felt the service should be done "table to table" instead so others didn't have to watch people eat while they waited for their meals. NA-D stated the residents complain about the meal service "all the time" as some people end up waiting for extended periods to be served on a daily basis. Further, NA-D stated she had mentioned these concerns to the charge nurse and kitchen staff before, however, no changes had been made so far to her knowledge.

On 12/17/19, at 6:01 p.m. R45 was attempted to be interviewed regarding the meal service and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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F 550	Continued From page 4 the wait time for his meal. R45 did not respond to the questions, however, just smiled and stated aloud, "Yea," and, "Good." On 12/18/19, at 9:42 a.m. R48 was interviewed about the meal service observed the evening prior. R48 stated he thought the female NA staff were purposefully making the males wait as it had to do with gender. R48 stated the extended waiting time after their tablemates had been served wasn't something he'd consider "bad, bad, but it's noticeable." When interviewed on 12/18/19, at 12:27 p.m. the administrator explained only one dining room was in use and they had been trying to develop and implement a new "in-kind dining" experience where the whole table would be served at one time. The administrator stated they had been trying to train staff on this new method and model to ensure residents were served together and in a timely manner, however, the administrator explained most of the evening shift staff had not been trained yet. Further, the administrator expressed the entire table of residents should be served their meal at the same time "so they can visit and eat" together and added having some residents wait could cause various issues including behaviors and poor customer service. A provided Passing Meal Trays policy dated 2019, identified resident would be served as they arrive in the dining room and trays should be passed " ... as quickly as possible."	F 550		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585		2/12/20

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F 585	Continued From page 5 §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her	F 585		

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F 585	Continued From page 6	F 585		

grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

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F 585	Continued From page 7 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure voiced concerns regarding care were addressed and acted upon for 1 of 1 residents (R50) who complained he was not assisted with a urinal appropriately. Findings include: R50's admission Minimum Data Set (MDS) dated 11/28/19, identified R50 had severe cognitive impairment and required extensive assistance with toileting and personal hygiene. When interviewed on 12/16/19, at 1:32 p.m. R50 stated the staff who help him "during the night" don't place the urinal correctly which causes urine to get all over him and the bed. R50 stated the staff "could be a little more careful," and added having urine splashed on himself "[doesn't] feel very good." R50 didn't express if he had reported these concerns to anyone else or not when questioned. On 12/18/19, at 8:45 a.m. nursing assistant (NA) -B was interviewed and explained R50 used a	F 585	Staff caring for R50 were re-educated on the how to properly place the urinal and the need to hold it in place when being used. R50□s care plan was updated to reflect his needs with toileting. All residents that use a urinal have the potential to be affected by a deficient practice in this area. All residents who utilize a urinal for toileting will be reviewed to ensure they receive the necessary care and treatment that is required as it relates to use of a urinal. All staff were re-educated on the grievance policy and the process for following up on resident concerns. At the resident council on 1/16/20, Activity Director will recommunicate to residents about the concern forms and the grievance process. Activities director or designee will complete Audits to ensure concerns/grievances are followed up on.	

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F 585	Continued From page 8 urinal at times to void. NA-B stated staff needed to remain with R50 while he uses the urinal and hold it in place while he voids so urine doesn't "go all over." R50 had complained the night staff don't hold it for him though, and they merely "put it in there and leave" which causes urine to spill onto the bed and R50's skin. NA-B stated they last heard R50 voice concerns about this approximately one week prior and reported the concerns to the nurse working. R50's medical record was reviewed and lacked evidence the voiced concerns with urinal assistance on the night shift had been assessed or addressed for resolution. Further, a provided untitled and undated document identified there had been no grievances filed pertaining to R50's concerns since his admission to the nursing home despite staff knowledge he was upset with these cares on the night shift. On 12/18/19, at 1:52 p.m. the activities director (AD) was interviewed and stated she was the person in charge of handling and addressing grievances at the nursing home. AD expressed she was unaware of R50's concerns pertaining to assistance with the urinal during the night and added she would consider the voiced concerns to be a grievance issue and she would follow up with him about them right away. Further, AD stated it was important to ensure voiced concerns pertaining to care were addressed and acted upon to ensure residents felt safe while residing at the nursing home. When interviewed on 12/18/19, at 2:23 p.m. the director of nursing (DON) stated she had not been told R50 had concerns with urinal use on the night shift. Further, DON expressed if the	F 585	One audit will be completed weekly for 4 weeks, then 2 audits monthly for 2 months and then one audit monthly thereafter. Audit Results will be brought to the full quarterly QAPI meeting for review and further recommendations.	

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F 585	Continued From page 9 floor staff had heard comments or concerns about such, they should have been reported and addressed "immediately." A provided Reporting Grievance policy dated 1/2017, identified a purpose of ensuring a procedure was in place for reporting and resolving grievances voiced by individuals receiving care and services in the nursing home. The policy outlined a grievance could be made either orally or in writing, and the grievance officer would receive, track and lead necessary investigations into expressed concerns. Further, the policy directed any received grievance would be investigated within 72 hours after the grievance is filed and documented accordingly with the results and resolution being provided to the complainant within 10 days.	F 585		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure personal grooming was performed for 1 of 5 residents (R42) reviewed for activities of daily living (ADL's) and who was dependent on staff for their care. Findings include: R42's quarterly Minimum Data Set (MDS) identified R42 had severe cognitive impairment, but exhibited no symptoms of delirium or	F 677	Little Falls Care Centers Policy is to ensure residents who require assistance with Activities of Daily Living do receive the assistance needed. R42 had facial hair removed on 12/19/19 R42s CP was updated to address facial hair preferences for staff to offer to remove facial hair and re-approach if refusal occur. All residents have a potential to be affected by a deficient practice in this	2/12/20

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F 677	Continued From page 10 depression. The MDS indicated R42 required extensive assistance of one staff member with dressing, bathing, and toileting, and required supervision with set up for personal grooming. R42's medical diagnoses included: dementia, anxiety, depression, and osteoarthritis (an inflammation of joints which may limit movement or cause increased pain). R42's care sheet, undated, identified R42 was independent with grooming,however, directed staff to offer to shave face. R42's care plan, printed 12/19/19, identified R42 was independent with grooming after set up. The care plan was revised on 11/10/19, and directed staff to offer to shave resident's face. On 12/16/19, at 9:27 a.m. R42 was observed seated in her recliner in her room and was noted to be neat and clean in appearance, however, R42 was observed to have visible white and gray colored facial hair on chin, going down neck which measured several millimeter (mm-a unit of measurement). On 12/19/19, at 10:10 a.m. nursing assistant (NA) -E stated R42 received help with mobility and received assistance with dressing and bathing. NA-E stated R42 had dementia and was forgetful. NA-E stated staff provided routine assistance to R42 with braiding of her hair, however, NA-E stated she had not provided assistance with facial hair. R42 stated staff were to monitor residents for facial hair while providing assistance with ADL's. On 12/19/19, at 10:19 a.m. NA-F stated R42 was set up to perform personal grooming and	F 677	area. All residents Careplans & Groupsheets were reviewed to ensure the care plan reflects facial hair and resident preferences in relation to grooming. NAR Group/Care Sheets were updated for staff to offer to remove facial hair and re-approach if refusal occur. NAR were re-educated on R42 POC and preferences for staff to offer to remove facial hair and re-approach if refusal occur. DON/designee will complete random resident audits. 2 residents/week for 4 weeks, then 1 resident/week for 2 months, then 1 resident monthly thereafter to ensure ongoing compliance. Audit results will be brought to the full quarterly QAPI committee for review and further recommendations	

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F 677	Continued From page 11 generally did "pretty well". NA-F stated staff were to monitor resident's appearance while providing cares. NA-F stated she had not provided R42 with personal assistance with facial hair, however, thought perhaps her family member provided assistance. On 12/19/19 at 10:23 a.m. R42 was observed to have facial hair present as previously noted. R42 stated "I don't like it when I have hair sticking out" and stated it made her feel embarrassed. On 12/19/19, at 10:27 a.m. family member (FM) -A stated she had observed R42 had facial hairs during visits. Additionally, FM-A stated R42's eyebrows have gotten long. FM-A stated R42 always took pride with personal grooming, and it was her expectation for staff to provide assistance with personal grooming. On 12/19/19, at 1:31 p.m. the director of nursing (DON) stated R42 had historically been unreceptive with assistance with facial hair, however, stated this was not reflective upon review of NA documentation, progress notes, or current care plan. R42 was visited at this time with DON and stated she would like assistance to pluck facial hairs. The facility policy, A.M. Cares (Early Morning Cares), dated 10/8/19, indicated the purpose of morning cares was to provided cleanliness, comfort, and neatness, as well as to promote the psychosocial well-being. The procedure identified staff were to assist with removal of facial hair as need per plan of care and resident abilities.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		2/12/20

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F 684	Continued From page 12 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess and develop interventions to ensure a developed skin rash was adequately treated to provide comfort and promote healing for 1 of 1 residents (R32) reviewed who complained of itching skin. Findings include: R32's annual Minimum Data Set (MDS) dated 10/12/19, identified R32 had intact cognition and no current skin issues. Further, R32's care plan printed 12/19/19, identified R32 was at risk for skin breakdown due to dermatitis. A goal was listed for R32 to, " ... maintain healthy skin status," and listed interventions to help her meet this goal including observing her skin daily with cares. The care plan lacked any specific current skin issues for R32. On 12/16/19, at 10:52 a.m. R32 was interviewed in her room. R32 stated she "[had] a skin problem" and felt she had developed eczema (a skin condition where patches of skin become inflamed, itchy, red, cracked, and rough) on various areas of her body. R32 stated the developed patches "drives me nuts" as they itch.	F 684	Little Falls Care Center Policy is to ensure each resident receives high quality care in relation to treatments provided and care received. Little Falls Health Services ensures a resident with a rash receives necessary treatment and services to promote healing and prevent further rashes to develop. R32 had Medical Director offer to complete a skin assessment on 12/19/19 and prescribe proper treatments upon assessment findings and resident refused. R32 interviewed by Case manager to complete skin assessment on 12/19/19 and refused stating, I am fine, and I want my Dermatologist to address. HUC had previously made Dermatology appointment (in November) for first available appointment. Scheduled appointment was made for 1/13/20. R32 CP was updated to address litchen simplex chronicus. TAR was updated with Dermatologist orders to apply Vanicream moisturizer	

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F 684	Continued From page 13 R32 explained she had reported these bothersome skin rashes to the floor staff who were putting some cream on them; however, R32 stated the applied cream "doesn't help" and she questioned if maybe something new was needed. R32's progress note dated 12/5/19, identified the nurse had identified, "15 skin deficits were noted on resident at the time of assessment. See skin and wound details." R32's corresponding Resident Transfer Sheet dated 12/12/19 to 12/19/19, identified R32 had multiple areas on her skin which were listed as, "Unspecified contact dermatitis, unspecified cause." When interviewed on 12/18/19, at 8:51 a.m. nursing assistant (NA)-B stated R32 had a skin rash which they described as, "I'd call it Eczema." NA-B explained R32 had these rash-type patches "through out her body" and often complains of them itching. NA-B stated the nurses hand the NA(s) "a cup with cream stuff in it" to apply to the areas R32 directs them to. Further, NA-B stated the skin looked "about the same" since the rashes developed a few weeks prior and NA-B added the rashes appeared "like it's not getting better." During interview on 12/18/19, at 10:03 a.m. trained medication aide (TMA)-A stated R32 had "really dry skin" and had developed some areas which appeared "scaly" and reddened. TMA-A stated they were applying a Sarna cream (used to cool and soothe itches while moisturizing the skin), and R32 kept a Vanicream lotion in her room which she was supposed to be applying once a day, too. TMA-A stated R32's developed skin rashes didn't appear any better since they had been putting the various creams on them,	F 684	everyday rub down and over entire body. Continue Xyzal 5 mg PO QD. Change to TMA 0.1% cream BID to affected areas. Sarna lotion at bedside, Patient can use PRN follow up in 4 months. All residents with Rashes have a potential to be affected by a deficient practice in this area. All residents with Rashes were reviewed to ensure interventions had been developed to treat the rash to provide comfort and promote healing. Care plans & TARs were reviewed to ensure they reflect the MD order for treatment. All Nursing Staff were reeducated on R32 New treatment orders and POC and process to inform the Nurse Manager who is responsible for ensuring treatment and Rashes are healing. DON/designee will complete random chart audits. 2 charts/week for 4 weeks, then 1 chart/week for 2 months, then 1 chart monthly thereafter to ensure ongoing compliance. Audit results will be brought to the full quarterly QAPI committee for review and further recommendations	

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F 684	Continued From page 14	F 684		

however, they did not look worse, either.

R32's medical record was reviewed and lacked evidence R32's developed skin rashes had been comprehensively assessed since they had developed on 12/5/19, to determine potential causes and/or interventions to promote healing and reduce the risk of worsening or other complications. Further, the record lacked evidence the facilty had re-visited their implemented treatment for efficacy despite the developed skin rashes not improving.

On 12/19/19, at 9:51 a.m. the director of nursing (DON) and registered nurse (RN) care management team (RN-A, RN-B, RN-C) was interviewed. They had identified R32's skin rashes as developing on 12/5/19, and had been applying Sarna lotion since then. DON stated they "maybe need to beef that up a bit," and order something else for R32's rashes. RN-A explained when a resident develops a skin issue, the staff assess it timely to find the "root cause right away" and make sure it's addressed. DON reviewed R32's medical record and verified it lacked any comprehensive assessment of the developed skin rash(es) to ensure timely healing and minimize the risk of complications. DON stated they would make sure R32's skin would now be assessed, and added it was important to ensure skin was assessed timely to help "fix the problem quicker" and prevent further complications.

A provided Skin Ulcer Protocol policy dated 11/2015, identified resident's would not develop skin ulcers or pressure sores unless it was clinically unavoidable, and appropriate cares and services would be provided to prevent, treat and

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F 684	Continued From page 15 monitor the progress of all healing ulcers. However, the policy lacked any specific direction, guidance or process for developed rashes or non-ulcer skin issues.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, care plan and develop interventions to provide comfort and reduce pain for 1 of 2 residents (R2) reviewed for pain management and who had recorded episodes of pain with range of motion (ROM). Findings include: R2's annual Minimum Data Set (MDS) dated 8/22/19, identified R2 had both short and long-term memory impairment, was totally dependent on staff for their activities of daily living (ADLs), and received scheduled pain medications, however did not receive any as-needed pain medications or non-pharmacological interventions for pain. Further, the MDS recorded R2 displayed no indicators of pain (i.e. vocal complaints, facial expressions) during the reference period. R2's Physician Order Sheet signed 8/28/19,	F 697	Little Falls Care Center Policy is to ensure that Pain management is provided to residents who require ROM services. R2 pain was comprehensively assessed and interventions to manage pain were reviewed. Plan of care was revised for resident to receive pain medication prior to getting out of bed in the morning and before receives ROM. All residents who receive ROM services will be assessed for pain with ROM. Interventions will be developed and care plan will be updated based upon the results of the assessment. Staff who are involved in developing and providing ROM services were re-educated on reporting and assessing any resident who is having pain with ROM. DON or designee will complete random audits of residents receiving ROM	2/12/20

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F 697	Continued From page 16 identified R2 consumed several medications. These included: Tylenol 1000 milligrams (mg) four times daily, and, gabapentin (an anti-convulsant) 100 mg twice a day. Further, R2 consumed aspirin 81 mg on a daily basis for a history of cerebrovascular disease. R2's most recent General - Other Comments note dated 12/8/19, identified R2 had been assessed for her pain. R2 was non-verbal most of the time, was unable to alert staff if she was having pain and consumed scheduled Tylenol, aspirin and gabapentin (an anti-convulsant medication) for pain which the note recorded as, " ... seems to be effective as resident has no non-verbal signs of pain." Further, the note identified R2 had low back pain and chronic pain which could increase her pain risk. R2's progress note dated 11/28/19, identified R2 had been, " ... expressing a grimace face when doing ROM [range of motion]." Further, a subsequent note dated 12/4/19, identified, again, R2 was expressing pain when ROM was done on her right knee. On 12/26/19, at 9:39 a.m. R2 was seated in her wheelchair in her room with her eyes closed. R2 had no obvious physical signs of pain at this time and appeared comfortable. During a subsequent observation on 12/17/19, at 5:38 p.m. R2 was seated in her wheelchair at a dining room table in the main dining room. R2 was being assisted with eating and again had no obvious physical signs or symptoms of pain. R2's care plan printed 12/19/19, lacked any recorded problem statements, goals or subsequent interventions to address R2's pain	F 697	services to ensure interventions are developed for comfort and to reduce pain during ROM when needed. 2 audits/week for 4 weeks will be completed, then 1 /week for 2 months, then 1 monthly thereafter to ensure ongoing compliance. Audit results will be brought to the full quarterly QAPI committee for review and further recommendations	

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F 697	Continued From page 17	F 697		

despite being assessed as at risk for pain due to her medical diagnoses and having recorded progress notes identifying she was having physical signs and symptoms of pain during her ROM cares.

When interviewed on 12/17/19, at 7:03 p.m. nursing assistant (NA)-A stated R2 used a mechanical lift to transfer. NA-A stated, at times, when care is being done for R2 she "kind of grimaces" like she is having pain. NA-A stated they had last seen R2 grimace with care a "couple weeks" prior and the nurses were aware of this.

R2's medical record was reviewed and lacked any evidence R2 had been comprehensively assessed for pain with ROM despite multiple recorded progress notes demonstrating pain during ROM cares and staff verbalizing they had observed grimacing and potential pain during the provision of cares to R2.

On 12/19/19, at 9:05 a.m. the director of nursing (DON) and registered nurse care team (RN)-A, RN-B and RN-C were interviewed. The DON reviewed R2's care plan and verified it lacked any developed problem statements, goals or interventions for R2's pain stating, "There is no pain addressed," and adding R2's pain should have been care planned to ensure "we have interventions in place." The DON explained a comprehensive pain assessment would include reviewing a resident's current interventions for pain, the pain characteristics and frequency, and seeing what had worked or not worked in the past for someone's pain. A pain assessment was completed routinely during the MDS schedule, however, one should also be completed

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F 697	Continued From page 18 "whenever [pain] presents itself." The DON reviewed R2's medical record and verified it lacked a comprehensive assessment for R2's pain despite the multiple recorded progress notes. DON stated they were going to set-up some additional pain monitoring for R2 and then review her progress notes to get a better handle on her pain and see if some additional interventions were needed. A provided Pain Management Policy dated 3/21/19, identified the facility would recognize and manage resident' pain to support their highest well-being. A resident's pain would be comprehensively assessed to help identify possible causes, characteristics and factors influencing the pain and an appropriate plan of care would be developed consistent with the assessment. Further, a procedure was listed which directed, "A Comprehensive Pain assessment will be completed by a Registered Nurse, on admission, with each MDS assessment thereafter, and when any new pain is identified."	F 697		
F 801 SS=C	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other	F 801		2/12/20

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F 801	Continued From page 19	F 801		

clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1

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F 801	Continued From page 20 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a certified and credentialed dietary manager oversaw and supervised food preparation and service(s) in 1 of 1 main production kitchen(s). This had potential to affect all 49 residents, visitors and staff who consumed food from the kitchen. Findings include: On 12/16/19, at 8:32 a.m. the initial kitchen tour was conducted. A single cook (CK)-A was present in the kitchen preparing various food items. CK-A was interviewed and explained she was the only staff present in the kitchen currently as they had been "short staffed as of late." CK-A explained there was no dietary manager (DM) who oversaw the kitchen currently, so the	F 801	A Culinary Director position is posted for LFHS. The position will be held by an employee that has the Certified Dietary Managers Course (CDM) or the facility will enroll the employee in the course. The facility has asked that the current dietician be able to assist more with the absence of the CDM Culinary Director. Dietician is able to assist facility with more clinical items in the absence of a CDM/Culinary Director. The Dietician is available frequently and for daily consultation as needed with employees of LFHS.	

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F 801	Continued From page 21	F 801		

administrator was filling in for the past few weeks since the previous DM had resigned. CK-A stated she was unaware if an registered dietician (RD) or anyone else was helping oversee the kitchen with the administrator. Further, when questioned on how residents were being assessed and care planned for their nutritional needs, CK-A stated the administrator was the person doing those tasks currently to her knowledge.

When interviewed on 12/18/19, at 12:11 p.m. the administrator stated she was acting as the current DM since the previous one had resigned a couple weeks prior. The facility used a contracted dietician (RD)-A, who came to the nursing home on a monthly basis and whom was available via telephone as needed. The administrator verified she lacked the required credentials to oversee the kitchen service as directed by Centers for Medicare and Medicaid (CMS) and expressed she was looking at going through the certification courses in the upcoming months.

On 12/18/19, at 12:50 p.m. RD-A was interviewed. RD-A explained she was present in the facility on a monthly basis for approximately eight hours, and was aware the previous DM at the facility had resigned weeks prior. RD-A stated the prior DM had been enrolled in the certification courses, however, there was currently nobody with the required certification managing the kitchen. RD-A stated she hoped the administrator would hire someone with the required certification or a dietician on a full-time basis. Further, RD-A stated she had not been asked or requested to increase her presence or oversight in the kitchen since the DM had

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F 801	Continued From page 22 resigned weeks prior. An undated, provided Culinary Director SNF - Department Manager job description identified the primary purpose of the position was to plan, organize, develop and direct the overall operation of the dietary department in accordance with current Federal and State regulations. A section labeled, "Education and Experience," identified the person holding the position must be a graduate of an approved dietary manager's course which met the requirements for State and Federal long-term care requirements or have the ability to complete the course in a timeframe determined by the administrator.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		2/12/20

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F 812	Continued From page 23 by: Based on observation, interview and document review, the facility failed to ensure cooking equipment was kept in a state of good repair to prevent potential cross-contamination and foodborne illness. This had potential to affect approximately 24 of 24 residents identified to use the defective device. Findings include: On 12/17/19, at 1:06 p.m. the kitchen was observed. Dietary aide (DA)-A was present inside the kitchen and removing cleaned dishes from the dishwasher. A single 12 inch frying pan was present in the cleaned dish rack which had been run through the facility' commercial dishwasher for cleaning. However, the pan remained visibly soiled with dried food on the outside of the pain. The pan was inspected. The inside of the frying pan was copper lined along the top with a black base; however, several areas of the copper lining had worn away and flaked off which exposed the black, pitted surface underneath of the lining. DA-A stated the pan was used on a daily basis to make eggs for the residents with 20 to 24 residents consuming the eggs made using the pan. DA-A verified the condition of the pan and stated it "need to be thrown away." DA-A stated the kitchen currently didn't have a dietary manager (DM); however, they had told the previous DM some new pans were needed to replace the old ones. DA-A explained some new pans did arrive, however, the staff were still using the old ones for some reason. When interviewed on 12/18/19, at 12:11 p.m. the administrator stated she was the acting DM since	F 812	The frying pan that was in question was disposed of. The facility will have the Dietician do an audits of the facilities cookware by January 15, 2020. Culinary Employees will be educated on this during their meeting on 1/16/2020. Audits will be completed monthly by our Dietician and audits will be reviewed monthly by the Administrator following the audit of the Dietician. All Audits will be reported to QAPI at the monthly meetings for 3 months and if 100% compliance, audits will be discontinued.	

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F 812	Continued From page 24 the previous DM had resigned a couple weeks prior. The administrator expressed the kitchen staff should not be using "an inappropriate pan" to prepare food with and old pans should be discarded as if the lining is removed and they are soiled, it could cause bacteria or chemical cross contamination which could impact the food. On 12/18/19, at 12:50 p.m. the consulting registered dietician (RD)-A was interviewed and stated staff should be disposing of cracked, old dishes which are in disrepair. RD-A stated she used to complete audits of the facility' cookware, however, had not done so for awhile and added using cookware in disrepair would be a "quality issue." A provided Using Sanitary Practices to Prepare, Serve, and Store Food policy dated 12/2019, identified all equipment and utensils for food preparation should be clean and in proper working order. A procedure was listed which include, "Employee will inspect all utensils prior to use ... will include looking for chips, rust, or cracks. Toss any utensils that have chips, rust, or cracks."	F 812		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 commercial dishwashing machines used in the main production kitchen was kept in a state of	F 908	The dishwasher was inspected by repairman Jake from Appliance Repair Center on 12/31/19 His report stated that there was nothing wrong with the	2/12/20

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F 908	Continued From page 25 good repair to prevent soiled dishware. This had potential to affect all 49 residents, staff and visitors who consumed meals from the main production kitchen. Findings include: On 12/17/19, at 1:06 p.m. dishwashing was observed in the main production kitchen. Dietary aide (DA)-A took several hard plastic trays and began to load soiled cups, utensils and small serving dishes into them. DA-A attempted to insert the loaded tray(s) into a single CMA Dishmachines EST Conveyor machine; however, there were several loaded, cleaned trays present on the opposite side of the machine which didn't allow more to be loaded. DA-A went to the clean side of the machine and began to visually inspect each cleaned piece of dishware as she placed them on the air-dry rack. However, several pieces of cleaned dishware; including serving spoons, metallic cooking pans, a single frying pan, and several coffee cups remained visibly soiled with food particles and clumping, wet food debris. DA-A stated they needed to inspect each removed item to "make sure they're clean" before allowing them to dry as the dishwasher wasn't getting items cleaned. DA-A removed several, still soiled, pieces of dishware from the clean racks and replaced them in trays waiting to be washed as "[they] aren't clean" and need to be re-washed. DA-A stated the dishwasher frequently was not getting items cleaned so they were having to re-wash things several times. DA-A explained one of the machines' bottom wash wands (long rods with holes present in them allowing water to be forcibly sprayed) had a missing bolt which caused the water to spray sideways and not upwards at the soiled dishes.	F 908	dishwasher, Jets are installed correctly, Jets should be at a 45 degree angle, the temps are correct on the rinse, the PSI is correct. Culinary employees will have education at their meeting on 1/16/20 that emphasis that dishes that are visibly soiled when coming into the dirty area of the kitchen will need to be scrubbed prior to going into the dish washer and any items that come out dry and are still dirty will be rescrubbed and washed. Staff will also be educated at the same meeting that silverware should always go through the dish machine twice and be observed for any food particles. Audits will be done randomly every week for all meals for 4 weeks and then monthly for 2 months and then quarterly. Audit will be done by the Administrator and/or Culinary Director. Results will be brought to the monthly QAPI meeting.	

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F 908	Continued From page 26	F 908		

This caused the dishes to not get cleaned. DA-A expressed the machine had been broken for the past several months, and then lifted up the front plating of the dishwasher and demonstrated the loose washing wand, pointing to where the bolt which secured the wand in an upright position was missing. DA-A said they had reported to machine being broken to the previous dietary manager (DM); however, it had not been fixed yet.

When interviewed on 12/18/19, at 12:11 p.m. the administrator was interviewed and expressed she was the current, acting DM for the kitchen as the previous DM had resigned a couple weeks prior. The administrator explained the CMA machine was the only dishwashing machine used and she had not been informed the machine was in disrepair and not getting the dishes cleaned. She added, "This is the first I have heard of this." The administrator stated the staff should be completing repair tickets and forwarding them to maintenance so items can be repaired. Further, the administrator stated it was important to ensure the dishwasher remained in good repair to help prevent food debris from remaining on the dishes and potentially getting someone sick.

During interview on 12/18/19, at 12:37 p.m. the environmental services director (ESD) stated the dishwashing machine was approximately five years old. ESD explained he had not been notified the machine was in disrepair and not cleaning the dishes "until today," and staff should have reported it when it was first found to be broken. ESD stated not addressing the broken dishwasher could be "a safety issue" since food debris was not being thoroughly removed from the dishware.

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F 908	Continued From page 27 An undated Model EST44 CMA Dishmachines manual was provided. A section labeled, "Regular Service and Maintenance Checklist," identified several things to be completed routinely to ensure safe operating condition of the machine which included, "Check Final Rinse Arms: the Rinse Jet Spray should be straight up & down." On 12/18/19, at 12:50 p.m. the consulting registered dietician (RD)-A was interviewed. RD-A stated she was unaware the facility' dishwashing machine was broken and not getting the soiled dishware clean. RD-A stated the machine needed to be fixed so dried food was not left on dishware and added she felt the machine not cleaning all the food debris off soiled dishware would not be a foodborne illness issue; however, added it was "not appealing." A provided Maintenance Policy dated 4/25/19, identified the facility would maintain a clean, homelike environment and listed a procedure which included, "All staff should be attentive to facility surroundings ... and fill out a yellow maintenance repair requisition form to notify maintenance of needed repair."	F 908		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **03 - EAST BUILDING** B. WING _____	**12/17/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Federal Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the Little Falls Care Center 2016 East Building Addition was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **03 - EAST BUILDING** B. WING _____	**12/17/2019**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as two buildings: Little Falls Care Center consists of two buildings separated by a 2 hour fire separation. Building 03, the East and West Building Addition are 1 story buildings without a basement built in 2016 and was determined to be Type II(111) construction. Building 04, the Mechanical Room building is a 1 story building without a basement and was determined to be Type II(111) construction. Since Building 03 was built under the 2000 edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code and Building 04 was built to the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code the two buildings were inspected separately.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **03 - EAST BUILDING** B. WING _____	**12/17/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility is fully protected with an automatic sprinkler system and also has a fire alarm system which includes corridor smoke detection throughout and in all common areas. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct one fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 64 of	K 712	Little Falls Care Center will conduct monthly fire drills in accordance with the regulations. Fire drills will be scheduled on an annual basis and ensure that they are random by week in the month, by date, by day of week, and by time of day	2/12/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 712	Continued From page 3 64 residents. Findings include: On facility tour between 9:00 a.m. to 12:00 p.m. on 12/17/2019, during the review of all available fire drill documentation and interview with a Maintenance Supervisor, the following deficient condition was found: 1. It was revealed that the facility did not conduct 1 day shift fire drill in the second quarter. This deficient condition was confirmed by a Maintenance Supervisor.	K 712	and will cover all three shifts. The Administrator will have the dates on her calendar along with the maintenance team and the Administrator will conduct a monthly audit times 3 months. Results for 3 months will be brought to the next quarterly Quality Committee to review and if there is 100% compliance, fire drills will then be monitored through the quarterly safety committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **04 - MECHANICAL ROOMS** B. WING _____	**12/17/2019**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Federal Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the Little Falls Care Center 2016 East Building Addition was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2020

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

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K 000	Continued From page 1	K 000		

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
445 MINNESOTA STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to:
FM.HC.Inspections@state.mn.us

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

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

2. The actual, or proposed, completion date.

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

The facility was inspected as two buildings: Building 04 - The Mechanical Room building is a 1 story building without a basement and was determined to be Type II(111) construction. Since Building 03 was built under the 2000 edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code and Building 04 was built to the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code the two buildings were inspected separately.

The facility is fully protected with an automatic sprinkler system installed and also has a fire alarm system which includes corridor smoke

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K 000	Continued From page 2 detection throughout and in all common areas that is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct one fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 18.7.1.6, during the last 12-month period. This deficient practice could affect 64 of 64 residents. Findings include: On facility tour between 9:00 a.m. to 12:00 p.m.	K 712	Little Falls Care Center will conduct monthly fire drills in accordance with the regulations. Fire drills will be scheduled on an annual basis and ensure that they are random by week in the month, by date, by day of week, and by time of day and will cover all three shifts. The Administrator will have the dates on her calendar along with the maintenance team and the Administrator will conduct a monthly audit times 3 months. Results for	2/12/20

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K 712	Continued From page 3 on 12/17/2019, during the review of all available fire drill documentation and interview with a Maintenance Supervisor, the following deficient condition was found: 1. It was revealed that the facility did not conduct 1 day shift fire drill in the second quarter. This deficient condition was confirmed by a Maintenance Supervisor.	K 712	3 months will be brought to the next quarterly Quality Committee to review and if there is 100% compliance, fire drills will then be monitored through the quarterly safety committee.	