



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 21, 2025

Revised Letter

Administrator
Little Falls Care Center
1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

RE: CCN: 245399

Cycle Start Date: July 9, 2025

Dear Administrator:

This letter will replace the letter sent earlier today, November 21, 2025. We have made the following correction to this letter. Mandatory Denial of Payment, effective October 9, 2025, did not go into effect for this facility. Substantial compliance was achieved on September 22, 2025.

On September 18, 2025, we notified you a remedy was imposed. On August 20, 2025, September 9, 2025 and October 1, 2025 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 22, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 9, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 18, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 9, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 22, 2025, the original triggering remedy, denial of payment for new

admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.
However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 23, 2025

Administrator
Little Falls Care Center

1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

RE: CCN:245399

Cycle Start Date: July 9, 2025

Dear Administrator:

On July 9, 2025 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 October 9, 2025 (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 January 9, 2026 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER Little Falls Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 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	
E0000	Initial Comments On 7/7/25 to 7/9/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/01/2025	
F0000	INITIAL COMMENTS On 7/7/25 to 7/9/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, The following complaints were reviewed with no deficiency issued: H53998448C/MN00105753 H53998447C/MN00107034 H53998449C/MN00109349 H53998409C/MN00111162 H53998410C/MN00112310 H53997693C/MN00114040 H53997693C/MN00114038 H53998429C/MN00114039 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments		F0000			08/01/2025	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0000		Continued from page 1 acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.		F0000			
F0550 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 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		F0550		F0550- Resident Rights/Exercise of Rights R15 has been asked if they prefer to have facial hair or not. R15 states she would like to be shaved. R15 preferences and grooming preferences are updated in care plan and Kardex in PCC. All residents with facial hair have the potential to be affected by this deficient practice. The dignity policy was reviewed by the DON with no revisions needed. The Facial Hair Removal policy was also reviewed by the DON with no revisions needed. Education to all staff on dignity and shaving will be provided by 8/15/2025. Process of shaving preference was reviewed by the management team and a preference paper assessment was initiated to complete on day of admission that includes shaving preferences. Once identified, the nurse managers will add the resident's shaving preference to the care plan. All resident's shaving preferences have been obtained and care planned. This was completed on 7/24/2025. A shaving audit will be completed and will be overseen by DON. Audits will be completed 3x/week for 3 weeks, 2x/week for 2 weeks, and weekly for one month. Findings from the audits will be brought to the next QAPI for review and further recommendations.	
						08/15/2025	

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F0550 SS = D	Continued from page 2 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 provide routine assistance with grooming of facial hair for 1 of 1 residents, (R15), reviewed for dignity. R15's annual Minimum Data Set (MDS) of 4/22/25, identified R15 was able to communicate her needs, although displayed moderate cognitive impairment. R15 had a limitation of range of motion (ability to move arm and leg) on one side. R15 required substantial/maximal assist of staff to perform tasks of personal hygiene, which included tasks of combing hair, shaving, and applying makeup. R15's medical diagnoses included hemiplegia/hemiparesis (mild to moderate weakness affecting one side of the body) affecting the right side of the body and arthritis (an inflammatory disease with swelling and/or tenderness of one or more joints. R15's care plan, revised on 6/25/25, indicated R15 had an ADL (activities of daily living-dressing, grooming, bathing, etc...) self-care performance deficit r/t (related to) disease processes of CVA (cardiovascular accident-stroke) and A-Fib (Atrial fibrillation-a disorder of the heart rhythm). The care plan identified R15 was able to complete personal hygiene after set-up, however, lacked indication of R15's preference for shaving/removal of facial hair, and R15's ability to complete task. On 7/7/25 at 12:47 p.m., R15 was observed in the dining room while eating lunch and was observed to have light facial hair notable on her upper lip. In addition, R15 was also noted to have 6-8 black whiskers, measuring 1/4 to 1/2 of an inch in length noted on, and under, her chin. During interview on 7/7/25 at 4:41 p.m., R15 stated having facial and whiskers bothered her, and she would like to have them shaved. R15 stated she was unable to shave by herself, and staff had not offered to shave her facial hair. On 7/8/25 at 1:20 p.m., R15 was observed sitting in the common area, as she was awaiting having her nails polished by activities. R15 was observed as she			F0550			

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F0550 SS = D	Continued from page 3 socialized with others. R15 continued to have whiskers on/under her chin and facial hair on her upper lip. On 7/9/25 at 7:43 a.m., nursing assistant (NA)-A was observed as she assisted R15 up from her bed. NA-A stated R15 had received full personal cares prior to this time, and she (NA-A) was only providing assistance with transfer from the bed to the wheelchair. NA-A stated R15 received assistance with bathing on Sunday morning. On 7/9/25 at 8:05 a.m., NA-B stated when she assisted with personal cares in the morning, she observed resident appearance. NA-B stated when she observed the need for shaving, she provided assistance to complete this task. NA-B stated she would also provide with assistance to complete personal cares when asked to do so by the resident/family. NA-B stated although shaving was generally completed on bath days, it should be done at any time the concern was identified. NA-B stated this was important for resident dignity. On 7/9/25 at 10:35 a.m., a follow up interview was completed with NA-A. NA-A stated shaving should be completed when the need for shaving was noticed. NA-A stated when noted, she would inquire if the resident would like to have facial hair shaved/removed. If removal of facial hair was desired, she would either provide assistance herself or inform nurse of the need for this to be done. NA-A stated she had not provided assistance previously to R15 for facial hair removal and was unsure if she had the equipment needed. On 7/9/25 at 12:51 p.m., NA-A stated she had followed up with R15 and had noted the facial hair on, and under, her chin, and her upper lip. NA-A stated R15 had an electric razor in her room and was provided assistance with shaving. NA-A stated personal shaving should be completed when assisted to bathe, however, if it was not completed, or noticed on shower day, it should be completed when noticed. NA-A stated it was important for this to be completed for personal well-being, and feelings regarding appearance. On 7/9/25 at 1:23 p.m., registered nurse (RN)-C stated she had observed facial hair on R15, however, was uncertain of R15's wishes and was unsure if this was care planned for R15. RN-C stated the care plan should reflect what R15's wishes were. RN-C stated she would expect upon admission, staff would identify what R15's wishes were, and this would have been subsequently added to the care plan to direct staff as to what cares			F0550			

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F0550 SS = D	Continued from page 4 were to be performed. RN-C stated if R15 was asked, and wished to have facial hair removed, she should have been provided with assistance. RN-C stated it was important to provide assistance with desired personal grooming to promote dignity. On 7/9/25 at 1:33 p.m., registered nurse case manager (CM)-A stated personal grooming should be completed for residents on bath day. If this was noted outside of the bath day, and resident wished to have shaving completed, this care could be completed at any time. CM-A stated this should be identified on the resident care plan to direct staff with cares. On 7/9/25 at 2:31 p.m., director of nursing (DON) stated if a resident was identified to have facial hair, and wished to have this shaved, the resident should be provided assistance with this. DON stated personal appearance should be observed with morning and evening cares. DON stated when identified the resident wished to have personal shaving, the care plan should have been updated to direct staff with care. DON stated this was important to provide assistance with shaving to resident to promote resident dignity. The facility policy, Facial Hair Removal, revised 11/20/23, identified removal of facial hair at the surface of the skin was important to keep residents clean and well-groomed. The policy identified the Nurse Manager, or designee, was to discuss the details of facial hair, it's grooming, and removal on an individual basis. Based upon the discussion with resident/caregiver, the resident's preference was to be noted in the resident's individual care plan.		F0550				
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to assess 1 of 1 residents (R7) for the ability to self-administer medications appropriately. Findings include: R7s quarterly Minimum Data Set (MDS) dated 6/24/25,		F0554	F0554- Resident Self-Admin Meds- Clinically Appropriate R7 has been reassessed for appropriateness to self-administer medications. R7 is able to self-administer and store the following medications: Emergen-C, AZO, Ibuprofen, Tums, Acetaminophen, and Zyrtec. R7 has an MD order for ok to self administer and store these medications. Each medication stored in the resident's room is identified on the EMAR and specifies that R7 can self-administer. Discussion was held with R7 to ensure any additional medications he may want to take will be discussed with nurse manager to obtain a provider order and assess if he is safely able to administer and store the medication; R7 agreed to this. Facility also held conversation with R7's wife to re-educate that any medications brought in needs to go through nursing so they can ensure there is an active order and assess R7 for safety with self-administration and storage of the medications.		08/15/2025	

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F0554 SS = D	Continued from page 5 identified R7 to have intact cognition with diagnoses of spinal stenosis (a narrowing of the spaces inside the bones of the spine), polyosteoarthritis (arthritis affecting multiple joints) benign prostatic hyperplasia (age-associated prostate gland enlargement) and frequent urinary tract infections (UTIs). R7's Medication Self Administration Assessment dated 10/7/2024, indicated he was appropriate to safely administer Emergen-C (an over-the-counter supplement containing vitamin C and B) to store this in his room. R7's Self-Administration of Medication assessment dated 4/1/25 was opened in the electronic medical record but had not been completed. R7's care plan dated 4/14/25, identified a focus regarding having an order for lotions, creams and Emergen-C to be self-administered and kept at bedside and directed staff to assess his ability to safely self-administer medications specified on admission/readmission, quarterly, with change in medication orders and with significant change in condition. R7's order listing report dated 7/9/25 identified physician orders for Emergen-C oral tablet chewable (multi-vitamin with minerals) give 1000 mg by mouth (PO) one time day for supplement. R7's physician communication and signed order dated 5/2/24 identified an order to use pyridium (a pain reliever for urinary symptoms) or AZO (an over-the-counter supplement containing pumpkin seed extract for urinary tract symptoms) R7's physician communication and signed order dated 5/3/25 identified staff asking for clarification regarding the indication for use of the previous pyridium or AZO order. R7's record lacked any other follow-up or clarifying orders regarding AZO. During observation on 7/7/25 at 12:32 p.m., a box of AZO supplement was noted to be in the basket of R7's eclectic scooter in his room. R7 stated he had been taking AZO every day on his own for UTI prevention. R7's Electronic medical record (EMR) banner only included instructions for self-administration storage of Emergen-C. R7's July 2025 medication administration record (MAR) dated 7/9/25, only included administration documentation of Emergen-C one time daily in the morning. When interviewed on 7/9/25 at 8:09 a.m., trained medication aide (TMA)-A stated if a resident asks to		F0554	Continued from page 5 All residents who have the ability to self-administer and/or store medications have the potential to be affected by this deficient practice. All residents who have the ability to self-administer and/or store medications in their rooms will be identified and assessed for safety. All care plans and orders will be updated to identify which medications the residents are safe to self-administer and store. All residents who self-administer and store any medications in their rooms will have a provider order specifying this. This will be completed by 8/15/2025. The Self-Administration of Medication by Residents policy was reviewed with no revisions needed. All nursing staff will be re-educated on the policy and to update a nurse promptly if they see any medications in a resident's room that are new, or that they feel the resident is not able to safely administer so they can be re-assessed. Education will be completed by 8/15/25. Self-Administration of Medication Audits will be completed and will be overseen by the DON. Audits will be completed 3x/week for 3 weeks, 2x/week for 2 weeks, and weekly for one month. Findings will be brought to QAPI for review and for further recommendations.			

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F0554 SS = D	Continued from page 6 self-administer medications, she would let the charge nurse know so they could determine if the resident was safe to do so. TMA-A stated she has not seen any medications in resident's rooms but if she had, she would alert the charge nurse to make sure the appropriate assessment had been completed. When interviewed on 7/9/25 at 8:27 a.m., registered nurse (RN)-A stated the normal facility process for medication self-administration is for a charge nurse or unit manager to assess the resident's ability to administer and store the medications in their room. RN-A stated resident self-administered medications were usually the over-the-counter eye drops, nose sprays and supplements and the nursing staff still stored and administered the prescription medications. RN-A stated the staff would check with the resident each day to determine if they took the medications as identified on the medication self-administration assessment and then document that on the MAR. RN-A stated she was unaware of any medications in resident rooms without an order or assessment. When interviewed on 7/9/25 at 8:30 a.m., unit manager RN-B stated the facility stored a resident's prescription medications on the unit locked cart. RN-B stated if a resident was assessed to be safe to take over-the-counter medications, they would be stored in their room. RN-B stated staff would check daily to see if they had taken the medication. During observation and interview on 7/9/25 at 8:45 a.m., RN-B performed a room check with R7's permission to look for any unaccounted-for self-administered medications. RN-B found several over -the -counter medications in half to full bottles including acetaminophen 650 milligrams (mg), ibuprofen 200 mg, AZO supplement and calcium carbonate (antacid) 500 mg. R7 stated he occasionally took the ibuprofen for knee pan but did not remember when he had last taken it. R7 stated he took the acetaminophen 650 mg every night for all over joint pain. R7 stated he took the Emergen-C every day and the calcium carbonate 500 mg for heartburn occasionally. R7 stated his spouse brings in over the counter medications for him. RN-B confirmed R7 had an order for acetaminophen 325 mg per requested need (prn) only which was not what R7 indicate he had been taking. RN-B confirmed R7 had no assessment or orders for the ibuprofen, AZO or calcium carbonate and the acetaminophen was being taken incorrectly per his current provider order. RN-B confirmed R7's last self-administration assessment had not been completed, and staff were unaware of the ibuprofen, AZO and calcium carbonate being taken and stored in his room.			F0554			

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F0554 SS = D	Continued from page 7 RN-B confirmed all medications should have a provider order and if indicated, be included in the self-administration assessment so facility staff and the resident's provider knew all medications being taken, to ensure he was taking them appropriately and self-administration could be documented. When interviewed on 7/9/25 at 2:11 p.m., the director of nursing (DON) stated when a resident indicates the desire to self-administer their medications an assessment needs to be completed, and the medication order itself should include the ok to self-administer and store in room. The DON stated the nursing staff should check with resident to determine if they had taken the medication per order and document on the MAR. The DON stated the staff must have been trying to clarify the AZO order from 5/2/34 but had not followed up with the provider when clarification was not received. The DON stated staff were not aware of the additional medications in his room. The facility policy Self-Administration of Medication by Residents dated 2/27/24, identified a periodic re-assessment by the interdisciplinary team (IDT) of the continued appropriateness of the self-administration will be completed, residents will be permitted to self-administer medications and/or retain in their rooms if approved by the IDT and ordered by the attending physician and nursing staff will ensure the EMR and care plan reflect the resident's self-administration of medications.		F0554				
F0577 SS = C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.		F0577	Little Falls Care Center has a 3-ring binder located in the front lobby labeled "MN Department of Health Nursing Facility State Survey Results for Past 3 Years" that is always available for residents, families, staff and other visitors to review. An audit was completed of the binder against the surveys located in the iQIES system and all missing survey results were printed/inserted in the binder in chronological order through August 2022. The Administrator will be responsible for ensuring all future surveys are inserted into the binder when results are received. The binder will be audited monthly for six (6) months by the Administrator and/or Designee to ensure it is in the proper location and all current surveys have been inserted. The Regional Director will audit the book		08/15/2025	

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F0577 SS = C	Continued from page 8 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure both recertification survey results, as well as additional complaint investigations, were available for review. This had the potential to affect all 54 residents residing in the facility, along with family, visitors and staff. Findings include: On 7/8/25, at 11:47 a.m., a review was completed of the facility survey binder, which was located just inside the front door next to the administrative window. The binder included the 2567 (A formal document which identified deficiencies cited during the survey process) from the previous recertification survey completed for the facility during the period of 4/15/24 to 4/18/24. A review of the information provided within the binder lacked additional documentation to identify any complaint investigation, and subsequent results of the investigative surveys which occurred following the last recertification period of 4/15/24 to 4/18/24. Upon review of complaint investigations documented in Aspen Central Office (ACO-A federal data base operated by CMS (Center for Medicare and Medicaid Services)), the following complaint investigations were on record on the following dates: 7/25/24 to 7/26/24: A complaint investigation was completed with citations issued. 8/22/24: A complaint investigation was completed without citations issued. 8/22/24 to 8/23/24: A complaint investigation was completed with citations with citations issued. 9/20/25: An offsite revisit was completed with correction of citations previously issued. 10/16/24 to 10/17/24: A complaint investigation was completed with no citations issued. 1/7/25-1/8/25: A complaint investigation was completed with no citations issued. 2/4/25: A complaint investigation was			F0577	Continued from page 8 after three (3) months and again at six (6) months to ensure it is in the proper location and all current survey results have been inserted. Results of all audits will be presented to the QAPI Committee for further audit direction.		

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F0577 SS = C	Continued from page 9 completed with citations issued. 3/6/25: An offsite revisit was completed for citations issued on 2/4/25 with correction completed, and no further citations issued. 3/27/25-3/28/25: An investigation was completed with no citations issued. On 7/8/25, at 12:53 p.m. the administrator stated he was unaware of the need to place the results of complaint investigation within the survey binder, available for review by residents, families, staff and visitor. The Administrator was only aware of the need to place the letter of findings within the binder, following complaint investigations. The Administrator stated "That's on me. I can remedy that right away." A facility policy was requested for the process of posting survey results was requested but was not available.	F0577		
F0812 SS = F	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 by: Based on observation, interview and document review, the facility failed to take appropriate steps to ensure the proper sanitization of dishware used for meal preparation and resident service when 1 of 1	F0812	On 7/8/25, the dietary manager contacted Environmental Services Director to service booster heater. The dishwasher & booster heater were inspected by ARC Food Service on July 10, 2025 and is in working order. Going forward, the dishwasher will have a booster heater that will hold temps high enough to meet sanitation requirements without additional chemicals. The Certified Dietary Manager (CDM) will educate staff on proper operation of DW along with temperature recording requirements and the procedure if the DW is not working properly. CDM will review and train all staff on Little Falls Health Services Cleaning Dishes/Dish Machine and Cleaning Dishes/Manual Dishwashing policies. Both of these policies were reviewed and approved by QAPI on 7/31/2025. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The CDM will audit 3 times per week for 3 weeks, then 2 times per week for 4 weeks, and then report results to QAPI Committee for ongoing monitoring recommendations. Once education is complete and if audits are 100%, CDM will conduct routine audits weekly to review document findings and submit to QAPI for ongoing monitoring recommendations.	08/15/2025

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F0812 SS = F	Continued from page 10 high-temperature commercial dishwashers was identified as not reaching adequate final rinse temperature (i.e., 180 F). This had potential to affect all 54 residents within the nursing home, staff, and visitors who consumed food from the main production kitchen. Findings include: On 7/7/25 at 10:53 a.m., an initial kitchen tour was conducted. A single CMA dish machine – EST Conveyor, model number EST-44H. On the upper left corner of the dish machine was a manufacturer’s label, which documented the following: “[National Science Foundation – NSF] Machine Operational Requirements as Manufactured by CMA [Dish machines] Hot Water Sanitizing Final Sanitizing Rinse Minimum Temperature: 180 Fahrenheit (F) Pump Rinse Tank Minimum Temperature: 160 F Wash Tank Minimum Temperature: 150 F Final Rinse Minimum Pressure: 20 PSI (pounds per square inch) Maximum Conveyor Speed: 6.75 [feet / minute] Model: EST-44H” This dish machine could also be operated as a low temperature / chemical sanitizing machine, with parameters of operation list on the affixed label. During this observation, it was not the facility had placed a clipboard, on the opposite wall from the machine, where the dietary staff were to record both wash and rinse temperatures each meal service. At the top of the current document, were the following instructions: “Wash must be at 180 and Rinse Must be 180 and no higher than 195”. In review of the documented the following was documented by the dietary staff: July 1, 25 – Supper: Wash 148 F, Rinse 166 F July 2, 25 – Breakfast was left blank July 3, 25 – Breakfast: Wash 150 F, Rinse 166 F		F0812				

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F0812 SS = F	Continued from page 11 July 4, 25 – breakfast and Lunch were blank, supper: Wash 165 F, Rinse 170 F July 5, 25 – Supper: Wash 160 F, Rinse 170 F July 6, 25 – Supper was left blank July 7, 25 – Breakfast was blank During interview on 7/7/25 at 11:02 a.m., certified dietary manager (CDM) verified the temperatures documented (and not documented) by the dietary staff, further verified the above temperatures did not meet temperatures listed as referenced on the document. CDM ran a tray with the facility’s temperature monitoring device, with the reading after the run of 167.7 F. Copies of temperature logs from March 2025 – current July 2025 were requested and received for review. In review of the dish washer’s temperature logs from March – June 2025; the following was documented: March 2025: Breakfast: 5 days were blank, 22 days wash = 150-165 F Lunch: 6 days blank, 21 days wash = 150-155 F, 4 days rinse = 160-165 F Supper: 6 days blank, 9 days wash = 150-165 F, 7 days 160 – 175 F April 2025: The sheet was a different format, documenting only for AM and PM and did not indicate required temperature ranges - AM: 5 days blank, 21 days wash = 135-175 PM: 14 days blank, 17 days wash = 150-170 F, 14 days rinse = 145-180 F May 2025: The sheet was a different format, documenting only for AM and PM and did not indicate required temperature ranges - AM: 2 days blank, 22 days wash temp between 150-165 F PM: 23 days blank, 8 days wash = 136-170 F, 8 days rinse = 145-170 F June 2025: Breakfast: 8 days blank, 10 days wash = 150-165 F, 3 days rinse = 160-165 F			F0812			

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F0812 SS = F	Continued from page 12 Lunch: 8 days blank, 11 days wash = 140-165 F, 8 days rinse = 150-155 F Supper: 23 days blank, 5 days wash = 130-152 F, 5 days 152-162 F During interview on 7/7/25 at 4:44 p.m., director of nursing (DON) was asked for the facility's infection surveillance from March 2025 through current date. DON stated the facility's infection preventionist (IP) was off today and would be returning the next morning and was unable to access the facility's infection surveillance until then. During interview on 7/8/25 at 12:56 p.m., the maintenance director (MD) stated he was not made aware of the low temperatures being recorded by dietary staff and had only been employed by the facility for the last 2.5 weeks. MD stated he has only been employed for the last 2.5 weeks and would have to look at the maintenance records for previous work orders of this concern. MD stated he was made aware of the temperature issue yesterday after survey's initial kitchen tour, and he adjusted the water temperature at that time During an interview on 7/8/25 at 1:04 p.m., CDM and MD. CDM stated there was work done on the machine back in June 2025, while there was a temperature issue reported at that time. A review of an invoice from ARC – Appliance Repair Center Inc., dated 6/16/25, documented the following by the service technician: “Checked over and traced temp issue to final rinse not kicking in. Found defective solenoid valve for final rinse. Picked up new solenoid valve and returned to install. Also found main wash motor leaking at intake compression nut. Removed wash pump motor and removed broken O-ring for compression nut connection. Reinstalled was pump motor assembly. Tested. Repair complete.” On 7/8/25 at approximately 1:10 p.m., reviewed of the facility's Infection Surveillance from March 1, 2025, through current dated was received and reviewed. It was noted the facility experience a Norovirus outbreak (the leading cause of vomiting and diarrhea, and foodborne illness), which affected both staff and residents within the facility. On 7/8/25 at 1:21 p.m., MD, who reviewed work orders for the facility stated there was no evidence from the			F0812			

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F0812 SS = F	Continued from page 13 prior maintenance director, for the low temperatures documented prior to the June 16, 2025, dish machine repair. Also provided was a ECOLAB service call, dated 3/18/25, which indicated the ECOLAB technician found the wash temp to be 160F and final rinse 183 F, which were acceptable for the technician. During an interview on 7/8/25 at 1:39 p.m., registered nurse / infection preventionist (IP) stated during her root cause investigation of the March 2025 Norovirus outbreak, it was found two nursing assistants on night shift thought they had food poisoning from outside the facility. Initially, the illness spread mainly with the facility staff then to the residents. The reported this to MDH (Minnesota Department of Health) and got the medical director involved. IP stated she did not include the dishwasher in the root cause analysis, while only 1 staff member of the kitchen staff had been infection. IP stated during the outbreak, all staff were educated to, "if you feel sick don't come to work", and other infection prevention steps while working. On the morning on 7/9/25, upon entering the facility, survey team members informed this surveyor, last evening the heating element of the dishwasher went out and the facility resorted to the use of disposable plates and other dinnerware. During interview on 7/9/25 at 8:49 a.m., the administrator (ADM) also informed surveyor of the dishwasher heating element going out last evening during evening meal service evening on the dishwasher. ADM stated they are hoping the repair person will be in today to fix it. ADM stated the meals are currently being served on disposable meal dishes, and those items needing to be served in regular tableware are being transported to the adjoining assisted living (AL) to be washed there. ADM stated all dietary staff have been educated to the process of transporting to and from the AL. In an interview on 7/9/25 at 10:10 a.m., dietary aid (DA)-A and DA-B, stated the heating element has not yet been repaired, and they are washing dishes over at the AL. Both Das stated they were educated on the process of washing dishes over at the AL. When asked for the process for reporting low temperatures on the dish machine, they both stated they would report to the CDM, and if the CDM was not available, they would report to the cook, who would them report to maintenance. In an interview on 7/9/25 at 10:15 a.m., the cook (Cook)-1, repeated the same scenario as did DA-A and			F0812			

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F0812 SS = F	Continued from page 14 DA-2. Cook-1 stated it neither CDM nor maintenance were in the building, the staff would call maintenance to come in. Cook-1 stated they would use disposable in the meantime. In review of the manufacture's Service and Parts Manual (Rev.2.08A dated 12/17-19) documented following for the dish machines manufacturer's specifications for water temperatures: OPERATING TEMPERATURE (by machine type low and high temp machines) Low Temp High Temp WASH RECOMMENDED 140° - 150° F 150° - 160° F PUMPED RINSE RECOMMENDED 140° - 150° F 150° - 160° F FINAL RINSE RECOMMENDED 140° - 150° F 180° - 195° F In review of a facility policy, entitled: Maintenance of Dish machine (undated) indicated the following: "NOTE: Consider contracting with the dish machine company to conduct a monthly maintenance check." In review of a facility policy, entitled: Cleaning Dished / Dish machine (undated) indicated the following: "NOTE: If the dish machine is not reaching proper temperature, please refer to Cleaning Dished and Manual Dishwashing policy to properly clean and sanitize dishes and cookware. No further policies were provided.	F0812			
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum,	F0880	F880- Infection Prevention & Control R14 is no longer on droplet precautions. R14 is not currently on any transmission-based precautions (TBP). All residents requiring TBP have the potential to be affected by this deficient practice. All staff will be re-educated on TBPs, including the appropriate PPE to be worn for droplet precautions. The Transmission Based Precaution Policy was reviewed with no revisions needed. All education to staff will be completed by 8/15/2025. The DON will oversee auditing on appropriate PPE with transmission-based precautions. Audits will be completed 3x/week for 3 weeks, 2x/week for 2 weeks, and	08/15/2025	

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F0880 SS = D	Continued from page 15 the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			F0880	Continued from page 15 weekly for one month. The audit findings will be brought to QAPI for review and further recommendations.		

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F0880 SS = D	Continued from page 16 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and document review, the facility failed to consistently implement transmission-based precautions (TBP) consistently, for 1 of 1 resident, R14, observed with droplet precautions in place. Findings include: R14's hospital discharge summary, dated 7/5/25, identified the diagnoses upon discharge included: acute multifocal pneumonia, acute congestive heart failure of unspecified type, and acute hypoxic respiratory failure secondary to the above. R14's medication orders upon discharge included DuoNeb (a medication given via a nebulizer which contains a steroid (albuterol) and an anticholinergic medication-ipratropium (a medication which relaxes the airway muscles to help breathing) four times a day. A nebulizer is machine which helps to convert liquid medication into a mist to inhale the medications, bringing it into the airways, and lungs. While hospitalized, R14 was treated with two broad spectrum antibiotics (medications which are given to treat both gram positive and negative bacteria) followed by a course of Levaquin, which was to be completed at the facility. R14 additionally had orders for oxygen via a nasal cannula (applied in nostrils) to help maintain her blood oxygen saturation levels at greater than 90%. R14's care plan of 7/2/25, indicated she was to receive oxygen therapy related to respiratory illness. R14 was to receive oxygen through a nasal cannula at two liters per minute as needed. On 7/7/25 at 6:44 p.m., during medication pass observation, licensed practical nurse (LPN)-A prepared medications for R14, and proceeded to room. Upon approaching the room, it was identified R14 was to be on droplet precautions. A sign was placed at the entrance of the door which identified to staff, and others, that "Droplet Precautions" were in place and		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2025	
NAME OF PROVIDER OR SUPPLIER Little Falls Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345			
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F0880 SS = D	Continued from page 17 anyone entering the room should use gown, gloves, mask, and protective eye wear. A cart with the necessary supplies was noted at the entry way to the room, with protective eye wear sitting on the top of the cart. LPN-A proceeded to don gown, gloves, mask and protective eye wear. Upon opening the door to enter resident room, nursing assistant (NA)-A was observed to be in the room, providing care to R14. NA-A was observed to have worn gown, gloves, and a mask in place, however, lacked eye protection. On 7/7/25 at 7:05 p.m., LPN-A exited room and removed the personal protective equipment (PPE-items worn to protect individuals from exposure related to illness and infection). LPN-A stated everyone is to wear all items of PPE designated on the sign posted for droplet precautions. LPN-A stated R14 had returned from the hospital with an upper respiratory illness. R14 required treatment with a nebulizer, which could cause increased coughing during and after treatment. LPN-A identified NA-A was not wearing protective eye and identified staff should have been aware. On 7/9/25 at 10:39 a.m., NA-A stated with residents on contact droplet precautions staff were to wear gloves, mask, and a gown. NA-A stated she was unaware of anything else to be worn. Upon review of signage with NA-A, NA-A identified that eye protection was to be worn. NA-A stated eye protection was important to wear, as the purpose of PPE was to provide protection from droplets within the room. Eye wear prevented droplets from getting into the wearer's eyes. On 7/9/25 at 1:23 p.m., registered nurse (RN)-C stated with any precautions, there was a sign outside of the room as to what is to precautions were to be used with R14. RN-C stated with droplet precautions, staff were to wear a mask and other PPE as identified on the sign outside of the room. RN-C stated, according to the sign with droplet precautions, staff were to wear gloves, gowns, masks, and eye protection. RN-C stated eye wear was important as the droplets could get up in your eyes. RN-C stressed the PPE for droplet precautions should be used by everyone going into the room, including those providing personal cares. On 7/9/25 at 1:33 p.m., registered nurse, clinical manager (CM)-A stated with droplet precautions, staff were to wear mask, goggles (protective eye wear), gloves and gown. CM-A stated this was important so fluids (droplets) don't go into the eyes of caregivers. CM-A stated everyone entering the room should follow		F0880				

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F0880 SS = D	Continued from page 18 the precautions. On 7/9/25 at 2:31 p.m., the director of nursing (DON) stated droplet precautions included gown, gloves, mask, and eye wear. DON stated there was the potential for droplets flying into the eyes of caregivers with resident coughing. DON stated it was her expectation that anyone in the room should be wearing the eye protection as a precaution against this. The facility policy, Transmission-Based Precautions, last reviewed/revised 1/21/15, indicated Droplet Precautions were to be implemented for residents with known, or suspected to be infected with infections pathogens (an organism known to cause disease) transported by respiratory droplets that are generated by a resident who is coughing, sneezing, or talking.		F0880				
F0908 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 good repair to prevent soiled dishware. This had potential to affect all 54 residents, staff and visitors who consumed meals from the main production kitchen. Findings include: On 7/7/25 at 10:53 a.m., an initial kitchen tour was conducted. A single CMA dish machine – EST Conveyor, model number EST-44H. On the upper left corner of the dish machine was a manufacturer's label, which documented the following: “[National Science Foundation – NSF] Machine Operational Requirements as Manufactured by CMA [Dish machines] Hot Water Sanitizing Final Sanitizing Rinse Minimum Temperature: 180 Fahrenheit (F) Pump Rinse Tank Minimum Temperature: 160 F		F0908	On 7/8/25, the dietary manager contacted Environmental Services Director to service booster heater. The dishwasher & booster heater were inspected by ARC Food Service on July 10, 2025 and is in working order. Policy "Maintenance of Dish Machine" has been reviewed and updated. This policy was approved at QAPI on 7/31/2025. Staff will be educated on the Maintenance Care Program and how to submit a maintenance request if the dish machine is not in working order or not heating to proper temps. Maintenance will conduct a monthly inspection of the dishwasher to ensure it is in proper working order and work with an external vendor as needed. This will be scheduled in the Maintenance software program and documented it is completed. An external vendor will conduct an inspection every 6 months of the dishwasher to ensure it is in proper working order. This will be tracked in our Maintenance Care program. Administrator will audit monthly Maintenance inspections for 5 months and the vendor inspection in the 6-month. All findings will be reported to QAPI for further audit direction.		08/15/2025	

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F0908 SS = F	Continued from page 19 Wash Tank Minimum Temperature: 150 F Final Rinse Minimum Pressure: 20 PSI (pounds per square inch) Maximum Conveyor Speed: 6.75 [feet / minute] Model: EST-44H” This dish machine could also be operated as a low temperature / chemical sanitizing machine, with parameters of operation list on the affixed label. During this observation, it was not the facility had placed a clipboard, on the opposite wall from the machine, where the dietary staff were to record both wash and rinse temperatures each meal service. At the top of the current document, were the following instructions: “Wash must be at 180 and Rinse Must be 180 and no higher than 195”. In review of the documented the following was documented by the dietary staff: July 1, 25 – Supper: Wash 148 F, Rinse 166 F July 2, 25 – Breakfast was left blank July 3, 25 – Breakfast: Wash 150 F, Rinse 166 F July 4, 25 – breakfast and Lunch were blank, supper: Wash 165 F, Rinse 170 F July 5, 25 – Supper: Wash 160 F, Rinse 170 F July 6, 25 – Supper was left blank July 7, 25 – Breakfast was blank In further review of requested dish machine temperature records, from March – June 2025, noted temperatures of both the washing cycle and final rinse cycle, being below the temperatures documented on the recording sheets. During interview on 7/8/25 at 12:56 p.m., the maintenance director (MD) stated he was not made aware of the low temperatures being recorded by dietary staff and had only been employed by the facility for the last 2.5 weeks. MD stated he has only been employed for the last 2.5 weeks and would have to look at the maintenance records for previous work orders of this concern. MD stated he was made aware of the temperature			F0908			

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F0908 SS = F	Continued from page 20 issue yesterday after survey's initial kitchen tour, and he adjusted the water temperature at that time During an interview on 7/8/25 at 1:04 p.m., certified dietary manager (CDM) and MD. CDM stated there was work done on the machine back in June 2025, while there was a temperature issue reported at that time. A review of an invoice from ARC – Appliance Repair Center Inc., dated 6/16/25, documented the following by the service technician found a defective solenoid valve for final rinse and a main wash motor leaking at intake compression nut, replacing them both. On 7/8/25 at 1:21 p.m., MD, who reviewed work orders for the facility stated there was no evidence from the prior maintenance director, for the low temperatures documented prior to the June 16, 2025, dish machine repair. Also provided was a ECOLAB service call, dated 3/18/25, which indicated the ECOLAB technician found the wash temp to be 160F and final rinse 183 F, which were acceptable for the technician. During interview on 7/8/25 at 1:04 p.m., 07/08/25 1:04 p.m. MD it would be important for the dietary staff to report low dishwashing temperatures to both the CDM and MD for repairs. On 7/8/25 at 1:21 p.m., MD, who reviewed work orders for the facility stated there was no evidence from the prior maintenance director, for the low temperatures documented prior to the June 16, 2025, dish machine repair. MD stated while he was new to his role, he was unaware form what source the temperature ranges listed to the kitchen temperature logs were sourced from. In review of the manufacture's Service and Parts Manual (Rev.2.08A dated 12/17-19) documented following for the dish machines manufacturer's specifications for water temperatures: OPERATING TEMPERATURE (by machine type low and high temp machines) Low Temp High Temp WASH RECOMMENDED 140° - 150° F 150° - 160° F PUMPED RINSE RECOMMENDED 140° - 150° F 150° - 160° F FINAL RINSE RECOMMENDED 140° - 150° F 180° - 195° F		F0908				

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F0908 SS = F	Continued from page 21 In review of a facility policy, entitled: Maintenance of Dish machine (undated) indicated the following: “NOTE: Consider contracting with the dish machine company to conduct a monthly maintenance check.” In review of a facility policy, entitled: Cleaning Dished / Dish machine (undated) indicated the following: “NOTE: If the dish machine is not reaching proper temperature, please refer to Cleaning Dished and Manual Dishwashing policy to properly clean and sanitize dishes and cookware. No further policies were provided.		F0908				

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399		(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - EAST BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/08/2025	
NAME OF PROVIDER OR SUPPLIER Little Falls Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345			
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K0000	INITIAL COMMENTS An annual Life Safety survey was conducted on 07/08/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Little Falls Care Center, Building 03 - East Building Addition was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. 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. 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: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or			K0000			08/01/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 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 detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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 Building Addition is 1 story buildings without a basement built in 2016 and was determined to be Type II(111) construction. Building 04, the West 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 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.		K0000				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - EAST BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2025
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K0000	Continued from page 2	K0000		
K0324 SS = F Bldg. 03	The facility has a capacity of 64 beds and had a census of 55 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by: Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, 19.3.2.5.3(9), NFAP 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2, 11.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings Include:	K0324	The kitchen hood was inspected on 7-14-2025 by Northland Fire Protection. The facility will ensure that the kitchen hood is reinspected on a twice annual basis and not to exceed a 6-month interval between inspections by using the facilities maintenance software (Maintenance Care) to pre-plan upcoming inspections for the hood system. Reminders will be used as a pre-inspection reminder for all upcoming inspections to ensure there is enough time to schedule the inspection vendor prior to the upcoming due date. The Administrator will audit the next scheduled hood cleaning to ensure timely completion prior to January 14, 2026.	08/15/2025

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K0324 SS = F Bldg. 03	Continued from page 3 On 07/08/2025 at 9:00AM, it was revealed by a review of available documentation that the most current range hood suppression system documentation was dated 12/31/2024. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.			K0324			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399		(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - MECHANICAL ROOM B. WING		(X3) DATE SURVEY COMPLETED 07/08/2025	
NAME OF PROVIDER OR SUPPLIER Little Falls Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345			
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K0000 Bldg. 04	INITIAL COMMENTS An annual Life Safety survey was conducted on 07/08/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Little Falls Care Center, Building 04 - East Building Addition was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. The facility was inspected as two buildings: Building 04 - The West 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 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 55 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are MET.		K0000			08/01/2025	

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 reverse for further 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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