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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KTH0

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: **7** (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 **12/08/2014** (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 **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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 :
Jessica Sellner, Supervisor 12/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/19/2014 (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
12/15/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5399

December 19, 2014

Mr. Scot Allen, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 56345

Dear Mr. Allen:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective November 11, 2014 the above facility is certified for:

45 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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 Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 12, 2014

Mr. Scot Allen, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 56345

RE: Project Number S5399025

Dear Mr. Allen:

On November 13, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 29, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On December 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 29, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 29, 2014, effective November 11, 2014 and therefore remedies outlined in our letter to you dated November 13, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245399	A. Building B. Wing	12/8/2014

Name of Facility	Street Address, City, State, Zip Code
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	**11/11/2014**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	**11/11/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**11/11/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	12/12/2014	29249	12/8/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/29/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: KTH0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00382

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(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**
(L5) **NORTHEAST 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 **10/29/2014** (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) :

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13.Total Certified Beds **45** (L17)

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Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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 :
Annette Truebenbach, HFE NE II 11/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 12/12/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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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
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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
Posted 12/15/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 13, 2014

Mr. Scot Allen, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 56345

RE: Project Number S5399025

Dear Mr. Allen:

On October 29, 2014, a standard 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7365

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 8, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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 form will be used as verification of compliance. 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, 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 January 29, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 29, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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 _____	10/29/2014

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
F 000	INITIAL COMMENTS 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. 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		11/11/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/21/2014

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 _____ B. WING _____	10/29/2014

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
F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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 _____	10/29/2014

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
F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to provide proper liability and appeal rights notices in a timely manner prior to termination of all Medicare skilled services for 1 of 3 residents (R63), reviewed for liability notice and beneficiary appeal rights. Findings include: R63 face sheet with an admission date of 5/23/14, indicated R63 had been admitted to the facility on Medicare part A services. A Big Stone (therapy) discharge summary dated 6/9/14, indicated R63 received therapy services through 6/5/14. There was no indication R63 had received a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization. During interview on 10/28/14, at 3:06 p.m. the	F 156	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely	

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F 156	Continued From page 3 administrator stated the facility had not given R63 the CMS 10123. The administrator stated R63 was discharged from therapy on 6/6/14, and discharged home on 6/7/14. During interview on 10/29/14, at 11:04 a.m. accountant-A stated R63 had not used all of the Medicare days, and stated normally discharge notices (CMS 10123) were given to the residents who are discharged from Medicare services. A policy for notice given to discharged Medicare residents was requested, but not provided by the facility.	F 156	because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility□s credible allegation of compliance. F156: The facility does inform each resident, both orally and in writing, of his or her rights and of all rules and regulations governing resident conduct and responsibility during the resident□s stay. Identified Resident: Resident R63 was receiving Medicare covered services, including physical and occupational therapy, and staff expected him to continue in residence and receive services for another week or two. Resident R63 had a routine doctor'□s appointment on 6/6/14 from which the resident returned with discharge orders. Staff missed providing him with his notice of beneficiary appeal rights as they completed necessary discharge actions to assist him in returning to his home yet that morning. Other Potential Residents: Survey Team members found all other residents in their random sample received proper notification. In the 10 month period following the facility□'s last survey, 57 residents discharged from skilled services.	

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F 156	Continued From page 4	F 156	Systematic Changes: Residents have been and will continue to receive proper liability and appeal rights notices. The facility has taken this opportunity to review its policy and practices and to remind appropriate staff of notification requirements, even residents discharging at their request and with no notice. Auditing/Monitoring: Facility Administrator or designee will monitor for compliance and will randomly audit 2 residents each week (if available) for 8 weeks to assure residents discharging from skilled services receive properly completed and documented liability and appeal rights notices. Facility Administrator or designee will report to facility□s Quality Assurance Committee (QA) for review and input. Completion Date: November 11, 2014	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 7 residents	F 176	F176: The resident□'s doctor and the facility does allow residents to	11/11/14

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F 176	Continued From page 5 (R41), who self administered medication was assessed to be safe to self-administer a nebulizer treatment. Findings include: R41 quarterly Minimum data set (MDS) dated 10/3/14, identified the resident had no cognitive impairment and was independent in most activities of daily living (ADL's). R41 was observed on 10/28/14, at 12:46 p.m. sitting in her wheelchair alone in her room with a nebulizer (a device used to administer medication in the form of a mist inhaled into the lungs) mask on, with the machine running. At 12:48 p.m. licensed practical nurse (LPN)-A entered the room and closed the door. R41 was observed again on 10/29/14, at 11:15 p.m. sitting in her wheelchair in her room with the nebulizer mask on with the nebulizer machine running. No staff was present at that time. At 11:18 a.m. nursing assistant (NA)-A entered the room to speak with R41. At 11:19 a.m. LPN-A entered the room. During interview on 10/29/14, at 11:20 a.m. registered nurse (RN)-A stated no assessment had been completed for R41's ability to administer a nebulizer treatment independently. RN-A stated until R41 had an assessment complete, a nurse should be present in the room the entire time while the medication is being administered. During interview on 10/29/14, at approximately 1:30 p.m. LPN-A stated prior to a resident self administering medications or treatments, an	F 176	self-administer drugs if the practice is determined to be safe. Identified Resident: Facility staff completed a self-administration of medication assessment for Resident R41 on 10/29/14 and the facility RN assessed the resident to be capable of self-administering her nebulizer treatment. The interdisciplinary team determined the resident was safe to practice self-administration of nebulizer treatments. The resident plan of care and treatment sheets were updated and self-administration of nebulizer treatments was implemented. Other Potential Residents: Facility RNs reviewed all other residents who were on nebulizer treatments on 10/29/14 in regards to self-administering medications and determined all other residents had been properly assessed, documented, implemented and identified on the resident□s care plan and treatment sheet. Systematic Changes: The facility□'s Director of Nursing reviewed the facility'□s policy regarding self-administration of meds on 10/29/14 and determined all requirements of the rule were being addressed. Licensed staff (RNs and LPNs) were reeducated on 11/11/14 regarding proper assessment and implementation of the facility□s policy on resident self-administration of medications.	

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F 176	Continued From page 6 assessment is required to be completed by the RN's to ensure a resident is safe to do so. LPN-A verified no assessment had been completed for R41 to ensure she was able to self administer a nebulizer treatment. LPN-A stated she had left R41 unattended while she was receiving her nebulizer treatment. During interview on 10/29/14, at 2:00 p.m. director of nursing (DON) stated the facility standing orders state self-administration of medication is determined by the RN assessment to determine if a resident is able to safely self administer their own medications. R41's Routine Standing Orders dated 10/0/14, signed by the medical director, instructed the resident may self-administer nebulizer treatment if a RN Assessment identified the resident is safe to do so. The facility policy titled Self Administration of Medications, undated, indicated any resident upon admission to the nursing home and during their stay expresses the desire to self-administer his or her own medication, may do so, pending the evaluation of the interdisciplinary team and permission of the physician.	F 176	Auditing/Monitoring: Facility Director of Nursing or designee, for a period of 8 weeks, will monitor for compliance and will review each resident admitted after 10/29/14 who has an order for nebulizer treatments or who expresses a desire to self-administer medications. This review will confirm that self-administration of meds is properly assessed, documented, implemented and identified in the resident'□s care plan and treatments sheets. When the monitoring is successful and complete, the facility will move to a management by exception process. Facility Director of Nursing or designee will report to facility'□s Quality Assurance Committee (QA) for review and input. Completion Date: November 11, 2014	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		11/11/14

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F 431	Continued From page 7 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin was discarded after the expiration date for 1 of 8 residents (R11) who received insulin and were reviewed during medication storage review. In addition, the facility did not provide separately locked, permanently affixed compartments for storage of controlled drugs. Findings include:	F 431	F431: The facility does contract with a licensed pharmacist who establishes a system of records of receipt and disposal of all controlled drugs. Drugs and biologicals are properly labeled and stored. Identified Resident: Facility staff immediately removed and properly destroyed Resident R11'□s	

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F 431	Continued From page 8 During observation of the 100/200 wing medication cart on 10/27/14, at 6:15 p.m., R11's Novolog FlexPen (a short acting insulin used to treat diabetes) was found with a handwritten open date of 9/19/14, and a date dispensed from the pharmacy of 9/18/14. Licensed practical nurse (LPN)-B was present at the time of the inspection, and stated the handwritten open was written on the insulin the day it was open so the staff knew when to dispose of the medication. LPN-B was unable to state how long this type of insulin was good for after opening and confirmed R11 was still receiving doses of the medication. R11 physician's order dated October 2014, instructed staff R11 was to have Novolog FlexPen five units daily at 11:00 a.m. for diabetes. R11's Medication Administration Record for the month of 10/14, indicated R11 had received the Novolog each day at 11:00 a.m. Review of the Novo Nordisk (Novolog FlexPen manufacturer) important safety information, indicated the medication once opened, had a time limit for use of 28 days. R11's insulin pen met the 28 day mark on 10/16/14, and was still being used 11 days later. During interview on 10/27/14, at 6:21 p.m. director of nursing (DON) stated all nursing staff had received training on insulin medication time limits on 10/15/14, and stated R11's medication was well past the 28 days per the manufacturer's instructions. During interview on 10/28/14, at 2:11 p.m. the facility consulting pharmacist stated R11's	F 431	Novolog FlexPen and obtained a replacement from pharmacy on 10/27/14. Other Potential Residents: Facility staff reviewed all other residents' medications, including Novolog FlexPens, on 10/27/14 and did not find any outdated medications, including insulin. Systematic Changes: Facility has taken this opportunity to review policies related to Medication Storage and Medication Expiration Time Limits. Appropriate staff were retrained on proper implementation, including medication expiration time limits, beginning 10/27/14 and completed by 11/11/14. Facility attached the locked medication storage to the physical plant and the padlock key was placed in a more secure location on 10/28/14. Auditing/Monitoring: Medication Expiration Time Limits: Facility RNs will monitor for compliance by randomly reviewing each wing cart two times per week for 8 weeks regarding proper implementation of medication expiration time limits. Med cart nurses will maintain responsibility for on-going compliance. Facility Administrator or designee will monitor Schedule II Storage one time each week for 8 weeks and randomly thereafter, to assure proper security.	

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F 431	Continued From page 9 Novolog should have been discarded after 28 days. Schedule II storage During observation on 10/27/14, at 6:21 p.m. there was a small safe located in the DON's office in the closet. Half of the closet was locked with a padlock, and the key to the padlock was stored in an unlocked drawer on the unsecured half of the closet. The safe was not permanently fixed in the closet. The DON stated the medications in the safe were controlled substances that were awaiting destruction with the consulting pharmacist which occurred monthly. The DON stated inside the safe were approximately 675 doses of controlled substance medications which included Fentanyl, Morphine, Vicodin and OxyContin. The DON stated her office door was locked when she was not in the building, however, the door remained open and unlocked when she was in the building and was going in and out of her office. During continuous observation on 10/28/14, from 1:17 p.m. to 1:25 p.m., (eight minutes) the DON's office door was open, the lights were on and no one was present in the office. Review of the facility policy titled Medication Storage Policy, undated, indicated the facility would not use outdated or deteriorated drugs. The policy also instructed Schedule II drugs would be kept under double lock and key in the DON's office until the pharmacy consult could dispose of it.	F 431	Director of Nursing and Facility Administrator or designee(s) will report to facility's Quality Assurance Committee (QA) for review and input. Completion Date: November 11, 2014	

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	245399	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/30/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Little Falls Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Lutheran Care Center is a 1 story building with no basement. It was constructed at four different times. The original building was built in the 1964 and was determined to be of a Type II(222) construction. In 1975 an addition was added to the east of 200 Wing that was determined to be Type II (222) construction. In 1992 an addition was added to the west of 100 Wing that was determined to be Type II (000) construction. In 2001 an addition was added to the southwest that was determined to be Type II(000). The facility is fully protected by a fire sprinkler system. The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces which is monitored for automatic fire department notification. Because the original building and the 3 additions are of the same type of construction type allowed for existing buildings, the facility was surveyed as one building. The facility has a capacity of 45 beds and had a census of 36 at the time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 13, 2014

Mr. Scot Allen, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 56345

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number S5399025

Dear Mr. Allen:

The above facility was surveyed on October 27, 2014 through October 29, 2014 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the first page of the order form should be signed and returned to thyis office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55107. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner at 320-223-7343. A written plan for correction of licensing orders is not required.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00382	A. BUILDING: _____ B. WING _____	10/29/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and documentation review the facility failed to ensure all residents' clinical	21426	Corrected	11/11/14

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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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21426	Continued From page 2 records contained completed documentation of Tuberculin skin test (TST) (a skin test used to check for tuberculosis infection) for 1 of 5 residents (R48) reviewed for TST test. Findings include: R48's first step TST injection was read on 7/21/12, and recorded as "negative," and did not indicate the actual measurement measurement of induration in millimeters (mm). R48's second step TST injection was documented as given 8/4/12. There was an (unknown) staff initial documented on 8/7/12, however, the documentation did not include if the TST result was positive or negative. During interview on 10/29/14, at 12:24 p.m. director of nursing (DON) stated documentation of TST should include a positive or negative reading, along with the mm of induration. DON was unsure where R48's TST results were located for the 2nd test done on 8/7/12. The facility Tuberculosis policy dated 4/10, instructed staff a reaction of 10 mm or greater will be considered, "Positive." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review the facility's process to ensure TB testing for residents is documented as required by state rule. the could also revise their policy to ensure millimeters of induration and the interpretations of the results are documented as per the recommendation of the Centers for Disease Control (CDC). Nursing staff could be re-educated on new processes and policy revision. An auditing system could be developed and reviewed by the facility's quality assessment ant assurance committee.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		11/11/14

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21565	Continued From page 3 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 7 residents (R41), who self administered medication was assessed to be safe to self-administer a nebulizer treatment. Findings include: R41 quarterly Minimum data set (MDS) dated 10/3/14, identified the resident had no cognitive impairment and was independent in most activities of daily living (ADL's). R41 was observed on 10/28/14, at 12:46 p.m. sitting in her wheelchair alone in her room with a nebulizer (a device used to administer medication in the form of a mist inhaled into the lungs) mask on, with the machine running. At 12:48 p.m. licensed practical nurse (LPN)-A entered the room and closed the door. R41 was observed again on 10/29/14, at 11:15 p.m. sitting in her wheelchair in her room with the nebulizer mask on with the nebulizer machine running. No staff was present at that time. At 11:18 a.m. nursing assistant (NA)-A entered the room to speak with R41. At 11:19 a.m. LPN-A entered the room. During interview on 10/29/14, at 11:20 a.m.	21565	Corrected	

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21565	Continued From page 4	21565		

registered nurse (RN)-A stated no assessment had been completed for R41's ability to administer a nebulizer treatment independently. RN-A stated until R41 had an assessment complete, a nurse should be present in the room the entire time while the medication is being administered.

During interview on 10/29/14, at approximately 1:30 p.m. LPN-A stated prior to a resident self administering medications or treatments, an assessment is required to be completed by the RN's to ensure a resident is safe to do so. LPN-A verified no assessment had been completed for R41 to ensure she was able to self administer a nebulizer treatment. LPN-A stated she had left R41 unattended while she was receiving her nebulizer treatment.

During interview on 10/29/14, at 2:00 p.m. director of nursing (DON) stated the facility standing orders state self-administration of medication is determined by the RN assessment to determine if a resident is able to safely self administer their own medications.

R41's Routine Standing Orders dated 10/0/14, signed by the medical director, instructed the resident may self-administer nebulizer treatment if a RN Assessment identified the resident is safe to do so.

The facility policy titled Self Administration of Medications, undated, indicated any resident upon admission to the nursing home and during their stay expresses the desire to self-administer his or her own medication, may do so, pending the evaluation of the interdisciplinary team and permission of the physician.

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21565	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could review and revise policies and procedures related to assessemnt of self administration of medications. Staff could be provided education and monitoring systems could be initiated to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21565		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin was discarded after the expiration date for 1 of 8 residents (R11) who received insulin and were reviewed during medication storage review. In addition, the facility did not provide separately locked, permanently affixed compartments for storage of controlled drugs. Findings include: During observation of the 100/200 wing medication cart on 10/27/14, at 6:15 p.m., R11's Novolog FlexPen (a short acting insulin used to	21615	Corrected	11/11/14

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21615	Continued From page 6 treat diabetes) was found with a handwritten open date of 9/19/14, and a date dispensed from the pharmacy of 9/18/14. Licensed practical nurse (LPN)-B was present at the time of the inspection, and stated the handwritten open was written on the insulin the day it was open so the staff knew when to dispose of the medication. LPN-B was unable to state how long this type of insulin was good for after opening and confirmed R11 was still receiving doses of the medication. R11 physician's order dated October 2014, instructed staff R11 was to have Novolog FlexPen five units daily at 11:00 a.m. for diabetes. R11's Medication Administration Record for the month of 10/14, indicated R11 had received the Novolog each day at 11:00 a.m. Review of the Novo Nordisk (Novolog FlexPen manufacturer) important safety information, indicated the medication once opened, had a time limit for use of 28 days. R11's insulin pen met the 28 day mark on 10/16/14, and was still being used 11 days later. During interview on 10/27/14, at 6:21 p.m. director of nursing (DON) stated all nursing staff had received training on insulin medication time limits on 10/15/14, and stated R11's medication was well past the 28 days per the manufacturer's instructions. During interview on 10/28/14, at 2:11 p.m. the facility consulting pharmacist stated R11's Novolog should have been discarded after 28 days. Schedule II storage	21615		

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21615	Continued From page 7 During observation on 10/27/14, at 6:21 p.m. there was a small safe located in the DON's office in the closet. Half of the closet was locked with a padlock, and the key to the padlock was stored in an unlocked drawer on the unsecured half of the closet. The safe was not permanently fixed in the closet. The DON stated the medications in the safe were controlled substances that were awaiting destruction with the consulting pharmacist which occurred monthly. The DON stated inside the safe were approximately 675 doses of controlled substance medications which included Fentanyl, Morphine, Vicodin and OxyContin. The DON stated her office door was locked when she was not in the building, however, the door remained open and unlocked when she was in the building and was going in and out of her office. During continuous observation on 10/28/14, from 1:17 p.m. to 1:25 p.m., (eight minutes) the DON's office door was open, the lights were on and no one was present in the office. Review of the facility policy titled Medication Storage Policy, undated, indicated the facility would not use outdated or deteriorated drugs. The policy also instructed Schedule II drugs would be kept under double lock and key in the DON's office until the pharmacy consult could dispose of it. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure controlled medications were securely double locked. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing	21615		

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21615	Continued From page 8 compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21615		