Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 13, 2023

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

RE: CCN: 245399
Cycle Start Date: June 29, 2023

Dear Administrator:

On September 7, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 2, 2023

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

RE: CCN: 245399
Cycle Start Date: June 29, 2023

Dear Administrator:

On June 29, 2023, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 September 29, 2023 (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 December 29, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	C 06/29/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 6/26/23 to 6/29/23, 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.	E 000		
F 000	INITIAL COMMENTS On 6/26/23 to 6/29/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53993102C/MN94606 H53993105C/MN90999 H53993106C/MN85922 H53993103C/MN84754 H53993021C/MN84697 H53993104C/MN93136 H53993104C/MN93146 H53993107C/MN91539 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/11/2023

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

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for	F 604		8/28/23

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F 604	Continued From page 2 restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 2 of 2 residents (R22 and R37) reviewed who had a seatbelt in their wheelchairs and/or a device in the bed to prevent them from getting up. Findings include: R22's quarterly Minimum Data Set (MDS) dated 5/2/23, indicated intact cognition, required extensive assistance with activities of daily living (ADL's) and was diagnosed with Parkinson's disease. The MDS further identified physical restraints were not used. R22's care plan dated 12/13/22, indicated R22 was at risk for falls related to Parkinson's disease and had the following interventions in place: monitor for bleeding/bruising/cognitive changes with any fall or other injury, monitor pain after a fall, anti-tip backs located on chair, anti-tip backs on wheelchair so wheelchair did not tip backwards when resident was transferring. R22's care plan further indicated R22 would safely operate and maneuver a motorized wheelchair. R22's care plan did not indicate use of a seat belt. R22's Restrictive Device assessment dated 4/28/23, indicated R22 did not use restraints. R22's current physician for June 2023 orders lacked orders for seatbelt restraint. During observation and interview on 6/26/23 at 12:36 p.m., R22 was sitting in his motorized	F 604	Little Falls Health Services was found to have inadequate practice for residents right to remain free from physical restraints. Inadequate practices were found under the following circumstances: R22 and R37 were found to utilize seat belts with their motorized powered vehicles. Both residents were found unable to remove these seat belts independently and Restraint Assessments failed to indicate the use of seat belts for powered motored vehicles. Occupation Therapies was consulted for re-evaluations to assist with completion of assessments to review the appropriateness of seatbelts as well as to ensure that residents can remove these independently. Potential of this occurring with other residents regarding use of seat belts with motored powered wheelchair. Occupational Therapy is to evaluate all residents with a motored powered vehicle to assess the need for seat belts and residents ability to apply and remove seat belts independently. Additional resources will be found for residents unable to adequately complete this task and orders will be obtained to ensure staff frequently remove the seat belt every two hours for at least 10-15 minutes per facility policy. Policies were reviewed, showing no changes needing to be made. Education to be provided to all staff regarding appropriate use of seat belts with motorized powered vehicles and the	

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F 604	Continued From page 3 wheelchair wearing a seat belt. R22 stated he was told he had to wear the seat belt when in his wheelchair. R22 stated he could occasionally put on the seatbelt but mostly required assistance with putting on, adjusting, and removing the seat belt due to hand tremors. R37's quarterly MDS dated 5/23/23, identified moderate cognitive impairment, was dependent on staff for most ADL's. Diagnoses included cerebral palsy, scoliosis, contractures and muscle weakness. The MDS further identified physical restraints were not used. R37's care plan dated 8/27/22, indicated R37 was at risk for falls due to history of falls, fidgeting in bed and placing self on the floor and had the following interventions in place: assist with mobility and transfers, encourage use of call light, low bed, fall mats to bilateral sides of bed, hourly rounding during high fall risk times, keep room free from clutter or obstacles, pool noodle placed to bilateral sides of bed. R37's care plan further indicated R37 would safely operate and maneuver a motorized wheelchair. R37's care plan did not indicate use of seat belt. R37's Restrictive Device assessment dated 5/18/23, indicated R37 utilized the following restraints: pool noodles to bilateral sides of bed and seatbelt while in motorized wheelchair. R37's current physician orders lacked orders for seat belt and pool noodle restraint. During observation and interview on 6/27/23 at 3:17 p.m., R37 was sitting up in his wheelchair	F 604	need to remove the seat belt every 2 hours for minimum of 10-15 minutes, per facility policy, if residents are unable to do so independently. Education to be completed at monthly nurses meeting; to be completed by 8/15/23. DON or designee to complete audits 3x / week for 4 weeks, then 1x / week for 4 weeks. Audits to reflect review of documentation for residents who cannot remove seat belts independently, to ensure that seat belts are removed per policy, every two hours for minimum of 10-15 minutes. Education to be completed with staff who have not signed off on the task indicating that this was completed. Results of audits will be brought to QAPI for review for further recommendations for monitoring. Completion date of 8/28/23. Little Falls Health Services was found to have inadequate practice for residents' right to remain free from physical restraints. Inadequate practices were found under the following circumstances: R22 and R37 were found to utilize seat belts with their motorized powered vehicles. Both residents were found unable to remove these seat belts independently and Restraint Assessments failed to indicate the use of seat belts for powered motored vehicles. Occupation Therapies was consulted for re-evaluations to assist with completion of assessments to review the appropriateness of seatbelts as well as to ensure that residents can remove these independently. Staff did not recognize seatbelts as restraints. Education was	

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F 604	Continued From page 4 with seat belt on. R37 stated he could not utilize the seat belt on his own. During observation and interview on 6/28/23 at 8:03 a.m., R37 was lying in bed with bilateral pool noodles tucked under the fitted sheet. R37 stated he was unable to remove the pool noodles from under the fitted sheet and was unsure of why they were in place. During an interview on 6/28/23 at 8:15 a.m., nursing assistant (NA)-F stated R37 had a history of climbing and rolling out of bed, the bilateral pool noodles kept him from getting out of bed on his own. NA-F stated R37 would not be able to remove the pool noodles under his fitted sheet. NA-F stated residents had to wear seatbelts if they were in a motorized wheelchair. NA-F stated R22 and R37 required assistance with their seatbelt. During an interview on 6/28/23 at 8:21 a.m., NA-D stated resident's who used a motorized wheelchair should have a seatbelt. NA-D stated R22 and R37 could not put on or remove their seatbelt on their own. NA-D did not recall receiving training on restraints. During an interview on 6/28/23 at 11:18 a.m., registered nurse (RN)-A stated pool noodles under a fitted sheet and seatbelts would be considered a restraint and would need to be addressed in the Restrictive Device assessment. RN-A stated a physician order and staff training were not required for restraint use. RN-A was unsure of why R22 used a seatbelt and was unsure if R22 could put on, adjust, or remove the seatbelt on his own. RN-A stated R37 used the seatbelt because of his scoliosis and the pool	F 604	provided to all staff regarding seatbelts being labeled as a restraint as well as interventions required for this. Potential of this occurring with other residents regarding use of seat belts with motored powered wheelchair. Occupational Therapy is to evaluate all residents with a motored powered vehicle to assess the need for seat belts and residents' ability to apply and remove seat belts independently. Additional resources will be found for residents unable to adequately complete this task and orders will be obtained to ensure staff frequently remove the seat belt every two hours for at least 10-15 minutes per facility policy. Policies were reviewed, showing no changes needing to be made. Education to be provided to all staff regarding appropriate use of seat belts with motorized powered vehicles and the need to remove the seat belt every 2 hours for minimum of 10-15 minutes, per facility policy, if residents are unable to do so independently. Education to be completed at monthly nurses meeting; to be completed by 8/15/23. DON or designee to complete audits 3x / week for 4 weeks, then 1x / week for 4 weeks. Audits to reflect review of documentation for residents who cannot remove seat belts independently, to ensure that seat belts are removed per policy, every two hours for minimum of 10-15 minutes. Education to be completed with staff who have not signed off on the task indicating that this was completed. Results of audits will be brought to QAPI for review for further recommendations for	

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F 604	Continued From page 5 noodles under the fitted sheet were used to keep him from getting out of bed because of his fall history. RN-A stated R37 would not be able to put on, adjust or remove the seatbelt or pool noodles on his own. An assessment for least restrictive device had not been completed for either R22 nor R37. During an interview on 6/28/23 at 11:26 a.m., director of nursing (DON) stated the facility did not use restraints, but seatbelts could be considered a restraint depending on how the seatbelt was used and if the resident was able to undo the seat belt or not. DON stated the resident would have to demonstrate that they could put the seat belt on and take it off independently. A resident's ability to use a seatbelt appropriately would be documented in the Restrictive Device assessment. DON stated they did not require a physician order or train staff regarding the use of restraints. DON stated R37 had bilateral pool noodles under his fitted sheet due to his extensive history of rolling out of bed and the pool noodles prevented R37 from rolling out of bed. DON confirmed R22 had not been assessed for the use of a seat belt restraint and further confirmed that R37's restrictive device assessment did not indicate whether R37 was able to demonstrate appropriate use of the seatbelt and pool noodles independently. No assessment for least restrictive device had been conducted. A facility policy use of physical device dated 10/22, indicated physical restraints were defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual could not remove easily which restricted freedom	F 604	monitoring. Completion date of 8/28/23.	

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F 604	Continued From page 6 of movement or normal access to one's body. The policy also indicated a physician's order for physical device was required and must specify the type of device, specific reason (medical symptom) and duration of application. The policy further indicated the physical device would be checked at least every 30 minutes by the nursing staff. Devices would be released and removed at least every two hours for 10-15 minutes and the resident would be reassessed for the need for continued use of the device.	F 604		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to provide assistance with activities of daily living (ADLs) for 3 of 4 (R42, R21, R37) dependent residents reviewed. Findings include: R42's Minimum Data Set (MDS) dated 4/11/23, identified he was cognitively intact with a diagnosis of Huntington's Disease. R42's care plan dated 6/26/23 identified he needed assistance with dressing and directed staff to assist him with dressing including buttons and fasteners and to encourage him to select clothing and participate in dressing and that he had a preference for wearing pajamas during the day.	F 677	Little Falls Health Services was found to have failed to provide assistance with activities of daily living. Inadequate practices were found under the following circumstances: R42, R21, and R37 were found to not have consistent assistance with completion of ADL cares; dressing and grooming needs. Care plans reflect appropriate level of assistance required for the residents listed above. Paper group sheets match the care plans in regard to the level of assistance required; group sheets are carried on NAR staff at all times during their shift. No changes to the care plans/group sheets were required; residents were assessed to ensure cares were completed per care plan.	8/28/23

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F 677	Continued From page 7 R42's nursing assistant (NA) group assignment sheets undated, instructed staff to provide assist of 1 staff for all cares. R42's order dated 5/17/23, directed staff to monitor for refusals of cares and to document in his progress notes. R42's progress notes dated 6/1/23 through 6/29/23, lacked any documentation of refusals of cares. During observation on 6/26/23 at 5:52 p.m., R42 was in his room wearing red and black plaid pajama bottoms with dried streaks of white and pink stains on the left leg and a black thermal type pajama top that was soiled across the entire front with various colored streaks of what appeared to be dried and crusted food stains. During observation on 6/27/23 at 8:45 a.m., R42 was in the unit common area finishing breakfast and was wearing the same pajamas with the same dried stains on the left pant leg and entire front of the shirt. During observation on 6/27/23 at 8:53 a.m., R42 returned to his room and transferred himself to bed to lay down with same soiled clothing on. During observation on 6/28/23 at 8:55 a.m., R42 was in the unit common area at a table awaiting breakfast and wearing the same pajamas with the same dried stains on the left pant leg and entire front of the shirt. During observation and interview on 6/29/23 at 11:40 a.m., R42 was in his room after breakfast	F 677	Potential of this occurring with other residents regarding inconsistency and incompletion of ADL cares; dressing and grooming needs. Residents throughout the facility were assessed to ensure grooming care needs were completed, shaving and nail care, per policy and dressing needs were addressed twice daily; in AM / PM and as needed. Nail kits were put together and placed in each shower room for residents who are not diabetic to ensure supplies are present with scheduled showers/baths to allow NAR staff to timely complete nail care. Rooms were audited to ensure supplies were available for those requiring shaving assistance as well as audits to ensure adequate clothing is available for all residents. Education to be provided to all staff regarding the requirement of completion of dressing and grooming needs for all residents according to policies and procedures. Education to be completed at monthly nurses meeting; to be completed by 8/15/23. Policies and procedures were reviewed; no needed adjustments at this time. DON or designee to complete audits 3x / week for 4 weeks, then 1x / week for 4 weeks. Audits to reflect the completion of daily dressing and grooming needs and to ensure tasks are also completed as needed. Tags to be placed within resident rooms near oral and shaving supplies; NAR staff are to return to DON as soon as found to indicate that cares were completed. Personal checks will be completed by DON or designee to ensure	

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F 677	Continued From page 8 with the same pajamas and stains noted the previous 3 days. R42 stated he needed help with changing his clothes but no one offered "in awhile." When interviewed on 6/26/23 at 11:41 a.m., (NA)-A stated R42 needed help with dressing and washing up in the morning and normally does not refuse assistance. NA-A stated R42 "gets food on his clothing with meals." NA-A had not assisted R42 with changing clothing today When interviewed on 6/29/23 at 11:47 a.m., NA-B stated R42 "will sometimes tell us he doesn't need help with dressing and grooming, but we all know he does otherwise he would keep wearing dirty clothes." NA-B stated if R42 "was told that his clothes were dirty he would agree to change them." NA-B did not let R42 know his clothes were soiled, nor did they assist R42 change their clothing. When interviewed on 6/29/23 at 11:49 a.m., registered nurse (RN)-A stated R42 required assist of 1 staff for all ADL's. RN-A stated on occasion, R42 "might say no when offered assistance with ADLs but in the last month there were no reports or documentation of refusals" by the NA's in his electronic medical record (EMR). RN-A verified R42 was wearing soiled clothing items and was not appropriate. RN-A stated R42's medical conditions of tremors related to Huntington's Disease made it more likely he would spill food and drinks on himself making it important to offer him assistance. RN-A verified R42's care plan and the NA group assignment sheets were current and the NA documentation of care completion was inaccurate for R42.	F 677	cares are properly completed. Personal checks to be completed by DON or designee regarding auditing of dressing for residents. Education to be completed with staff found to not complete tasks per facility policy. Results of audits will be brought to QAPI for review for further recommendations for monitoring. Completion date of 8/28/23.	

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On 6/29/23 at 2:29 p.m., the director of nursing (DON) stated R42's care plan indicated he required 1 staff assist with ADLs. The DON stated her expectation were that care plans are followed, all residents requiring assistance for dressing and grooming would receive it, and any refusals of assistance would be communicated and documented so alternative approaches could be tried.

The facility policy dated October of 2022, identified personal cares for each resident would be provided in the morning and at bedtime and as needed, to promote cleanliness and comfort.

R21's quarterly MDS dated 4/25/23, identified moderate cognitive impairment, was dependent on staff for most ADL's. Diagnoses included disease of spinal cord, and upper and lower extremity contractures.

R21's care plan dated 12/29/22, indicated R21 was totally dependent on staff for grooming hygiene, dressing, and bathing.

During observation and interview on 6/26/23 at 12:20 p.m., R21's face was unshaven, and fingernails were long. R21 stated he had not been shaved in a few days and did not remember the last time he received oral care. R21 stated he was supposed to receive assistance with oral care and shaving every day, but staff did not offer to help him. R21 stated his nails were longer than he preferred and would like them trimmed.

During an observation on 6/28/23 at 7:40 a.m.,

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nursing assistant (NA)-C and NA-F assisted R21 morning cares but did not offer to shave his face, or assistance with oral care.

R37's quarterly MDS dated 5/23/23, identified moderate cognitive impairment, was dependent on staff for most ADL's. Diagnoses included cerebral palsy, scoliosis unspecified contractures and muscle weakness.

R37's care plan dated 8/27/22, indicated R37 was dependent on staff for grooming hygiene, dressing, and bathing.

During an observation on 6/28/23 at 8:03 a.m., R37's face was unshaven, and fingernails were long. NA-F and NA-A assisted R37 with morning cares but did not offer to shave his face or assistance with oral care.

During an interview on 6/28/23 at 5:23 p.m., family member (FM)-A stated he had concerns that R37 was not getting his teeth brushed, face shaved, or nails trimmed. FM-A stated R37 was not one to complain or speak up if his cares were not completed. FM-A stated he addressed these concerns at each care conference, but it continued to be a problem. FM-A expected R37 to receive assistance with oral care and shaving at least daily and nail care weekly and as needed.

During an interview on 6/29/23 at 9:15 a.m., with NA-B and NA-G, NA-G stated both R21 and R37 required assistance with morning cares which included oral care and shaving. NA-G stated nail care was completed weekly by the NA's if the resident was not diabetic.
-NA-B stated R21 sometimes refused cares but could be redirected and R37 never refused cares.

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F 677	Continued From page 11 During an interview on 6/29/23 at 10:02 a.m., RN-A stated oral care and shaving assistance was included in morning and bedtime cares. RN-A stated nail care for non-diabetic residents was completed weekly by the NA's and for diabetic residents it was completed weekly by a nurse. RN-A confirmed R21 and R37 both should have been shaved and provided oral care. RN-A further confirmed R21 and R37 nails were long and should have been trimmed. During an interview on 6/29/23 at 10:09 a.m., DON stated R21 and R37 were dependent on staff for ADL's and should have received assistance with oral care and shaving daily. DON confirmed R21 and R37 were not diabetic and nail care should have been completed weekly on their bath day and as needed. DON stated nail care was especially important for R21 and R37 so not to cause injury to self-due to hand contractures. A facility policy resident cares dated 10/22, indicated the facility provides cares for each resident in the morning and at bedtime and as needed, to promote cleanliness and comfort. A facility policy bath (shower) dated 9/06, indicated to trim toenails and fingernails (have the nurse trim nails if diabetic).	F 677		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		8/28/23

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F 688	Continued From page 12 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure range of motion exercises were completed to prevent further contractures for 4 of 4 residents (R15, R29, R21 and R37) reviewed for range of motion (ROM). In addition, the facility failed to ensure an ordered hand splints was applied consistently to maintain range of motion for 1 of 1 resident (R21) reviewed for position and mobility. Findings include: R15's annual Minimum Data Set (MDS) dated 5/23/23, identified severe cognitive impairment. R15 was dependent on staff for all ADL's. R15's diagnoses included post-concussional syndrome (persistence of various symptoms such as headache, dizziness, problems with concentration and memory weeks after a mild head injury), dysphagia (difficulty swallowing) and contracture (permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) of left wrist.	F 688	Little Falls Health Services was found to have inadequate practice to ensure that range of motion exercises were completed to prevent further contractures as well as failed to ensure hand splints were applied consistently to maintain range of motion. Inadequate practices were found under the following circumstances: R15, R29, R21 and R37 were found to not have consistent assistance with ROM to prevent further contractures. R21 was found to show inconsistent frequency of the use of hand splints for positioning and mobility. Care plan and group sheets were reviewed to ensure that the need of splints were noted for R21; group sheets were found to have appropriate information noted but care plan failed to list this information. Care plan for R21 has now been updated. Residents R15, R29, R21 and R37 and their current restorative programs were evaluated by therapies,	

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R15's care plan dated 8/26/22, indicated R15 had a decline in ROM (range of motion) related to dementia and accident history as evidenced by non-ambulatory and decreased movement in all extremities.

R15's restorative program note dated indicated R15 would receive passive ROM to bilateral upper and lower extremities all motions x (times) 10 for 3-6 days a week.

During observation and interview on 6/26/23 at 12:51 p.m., R15's wife stated that both R15's hands are contracted, with the left hand being the worst, and that R15 needs ROM done with him, but is not always getting it like he is supposed to.

During record review, family had brought concerns regarding ROM that were reviewed at R15's quarterly care conferences scheduled on 2/28/23 and 6/5/23. During care conferences, family had requested ROM to be done.

R29's quarterly MDS dated 5/23/23, identified R29 was cognitively intact and received extensive assist with all ADL's. R29's diagnoses included multiple sclerosis (potentially disabling disease of the brain and spinal cord (central nervous system), neuromuscular dysfunction of bladder (either nerves or the brain cannot communicate effectively with the muscles in the bladder), rhabdomyolysis (breakdown of skeletal muscle due to direct or indirect muscle injury), history of transient ischemic attack (TIA) (a temporary period of symptoms similar to those of a stroke), and weakness.

R29's care plan dated 8/27/22, indicated R29 had

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changes were made to plan of care and group sheets updated to reflect. Staff have been educated on changes to plan of care.
Potential of this occurring with other residents regarding inconsistencies with Restorative Programs as well as inconsistency with use of hand splints. Occupational Therapy is to evaluate residents requiring the need for orthotics and has provided education and photo reference to floor staff for proper donning and doffing of splints. Care plans and group sheets to be reviewed to ensure proper documentation is noted for the use of hand splints as well as frequency and times of use. Group sheets to be updated to reflect restorative programs in place for each resident. Activities department to be included for completion of restorative programs to allow for group activities for completion of range of motion.
Education to be provided to all staff regarding the importance of restorative programs and the need to maintain range of motion. Education to be completed at monthly nurses meeting; to be completed by 8/15/23. Policies and procedures were reviewed, no needed adjustments at this time.
DON or designee to complete audits 3x / week for 4 weeks, then 1x / week for 4 weeks. Audits to reflect review of documentation for completion of restorative nursing programs. Orders to be placed within EHR system for all resident's who have orders for use of splints/braces. Orders will serve as a reminder for nursing to follow-up on

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F 688	Continued From page 14 a deficit in ROM related to multiple sclerosis as evidenced by non-ambulatory, lower extremity spasticity and RLE misalignment. Restorative program not dated indicated R29 would receive UE PROM and LE PROM 3-6 days a week. During interview on 6/28/23 at 1:50 p.m.., nursing assistant (NA)-H stated the restorative aides assist with the ROM program. Restorative aides need to be trained to perform ROM exercises. NA-H stated that facility does not have any restorative aides currently and the ROM exercises are not being performed. During interview on 6/28/23 at 2:01 p.m., trained medication aide (TMA)-A stated the facility is supposed to have restorative aides that would perform all ROM exercises for residents. TMA-A stated that because the facility is short-staffed, the restorative aide (if they have one scheduled) will get pulled to work on the floor so ROM exercises are not getting done. During interview on 6/29/23 at 3:05 p.m., physical therapist assistant (PTA) stated R15 was last seen on 9/12/22. PTA stated R15 has significant tone and has ROM ordered to help decrease tone. PTA indicated if ROM exercises are not being done, R15's tone would decrease making if difficult to transfer with a PAL lift and would then have to switch to a Hoyer lift. PTA indicated that R29 was seen on 9/7/22 when ROM exercises were started. PTA stated the ROM exercises ordered are to help decrease muscle spasticity. PTA indicated if ROM exercises are not being done, spasticity would increase causing R29 to not be able to use the Sara Steady (transferring	F 688	placement that is to be performed by NAR staff. Education to be completed with staff who do not place orthotic devices. Results of audits will be brought to QAPI for review for further recommendations for monitoring. Completion date of 8/28/23.	

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device).

During interview on 6/29/23 at 3:33 p.m., director of nursing (DON) stated she expected all restorative programs would be followed, "when we have a restorative aid available." DON stated that she was not sure if the program was being followed due to orders/recommendations. DON stated it was important to follow all restorative programs to prevent decline in resident's abilities.

During interview on 6/28/23 at 11:48 a.m., RN-B stated she oversaw the restorative programs and training of restorative aids. RN-B stated the facility did not have enough restorative aids to follow through with current restorative programs and the frequency of how often restorative programs were being completed varied from day to day depending on scheduling.
-Restorative program audit indicated over a period of three months (3/1/23-6/28/23) R15 received PROM in his arms and hands eleven times and PROM in his legs and feet eleven times. R29 received active ROM is her legs and feet six times and active ROM in her arms and hands four times and active ROM in her neck one time.

A facility policy restorative nursing program dated 4/20, indicated the facility will have a restorative nursing program that promotes a residents' ability to achieve and/or maintain their optimal function, in accordance with the resident's comprehensive assessment and person-centered plan of care.

R21's quarterly MDS dated 4/25/23, identified moderate cognitive impairment, was dependent on staff for most ADL's. Diagnoses included

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disease of spinal cord, cerebral vascular accident (damage to the brain from interruption of its blood supply) (CVA) and upper extremity (UE) and lower extremity (LE) contractures.

R21's care plan dated 12/29/22, indicated R21 had a deficit in ability to transfer, range of motion (ROM) and passive ROM (PROM) related to CVA with right hemiparesis (muscle weakness or partial paralysis on one side of the body), bilateral UE and LE weakness.

R21's therapy communication document dated 12/23/22, indicated to apply splints to R21's wrist/hands and gave directions on how to apply each splint.

R21's restorative program note dated indicated R21 would receive transfer training 3-6 times a week, UE PROM 3-6 days a week, LE PROM or active ROM exercises 4-6 times a week.

During observation and interview on 6/26/23 at 12:14 p.m., R21 stated he should wear bilateral hand splints due to hand contractures and should complete ROM exercises for his neck, hands, arms, and legs to maintain his strength. Two hand splints were noted on R21's nightstand. Two pictures taped to R21's wall indicated correct placement of bilateral splints for staff to reference.

During an observation on 6/28/23 at 7:40 a.m., nursing assistant (NA)-C and NA-F assisted R21 with morning cares and did not offer to apply bilateral hand splints or perform his restorative program.

R37's quarterly MDS dated 5/23/23, identified

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moderate cognitive impairment, was dependent on staff for most ADL's. Diagnoses included cerebral palsy, scoliosis unspecified contractures and muscle weakness.

R37's care plan dated 8/27/22, indicated R37 had a deficit in LE ROM related to spastic diplegic cerebral palsy as evidenced by impaired ROM and contractures.

R37's restorative program, not dated, indicated R37 would receive UE PROM and LE PROM 3-6 days a week.

During an observation on 6/28/23 at 8:03 a.m., NA-F and NA-A assisted R37 with morning cares but did not offer restorative program.

During an interview on 6/28/23 at 7:58 a.m., NA-C confirmed R21 had two hand splints in his room but stated she had not put them on because the NA group sheet did not indicate he used them. NA-C was not aware that R21 or R37 had a restorative program stating it was not indicated on the group sheet and that is what she follows when completing resident tasks.

During an interview on 6/28/23 at 11:18 a.m., registered nurse (RN)-A stated adaptive equipment and restorative programs would be listed on the NA group sheets and in the resident's care plan. RN-A confirmed the NA group sheet did not indicate R21 used bilateral hand splints or that R21 and R37 had a restorative program in place.

During an interview on 6/28/23 at 11:26 a.m., director of nursing (DON) stated adaptive equipment, ROM, restorative programs should be

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listed on the NA group sheets and in the resident's care plan. DON stated only trained restorative aids could complete restorative programs and they only had a few on staff. DON stated she expected all restorative programs would be followed when we have a restorative aid available. DON stated it was important to follow all restorative programs to prevent resident decline and to maintain current level of abilities.

During an interview on 6/28/23 at 11:48 a.m., RN-B stated she oversaw the restorative programs and training of restorative aids. RN-B stated the facility did not have enough restorative aids to follow through with current restorative programs and the frequency of how often restorative programs were being completed varied from day to day depending on scheduling.
-Restorative program audit indicated over a period of three months (3/28/23-6/28/23) R21 received PROM in his arms and hands twelve times and PROM in his legs and feet twelve times. R37 received UE PROM eight times and LE PROM nine times.

A facility policy restorative nursing program dated 4/20, indicated the facility will have a restorative nursing program that promotes a residents' ability to achieve and/or maintain their optimal function, in accordance with the resident's comprehensive assessment and person-centered plan of care.

A facility policy splints, braces, immobilizer's dated 10/22, indicated all orders for splints, braces and immobilizer's will be scheduled in the resident's electronic record. All care plans and NA care guides will be updated by charge nurse to include directions on any splints, braces, or immobilizer's. Physical or Occupational therapy

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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 688	Continued From page 19 will provide education to nursing staff on how to apply/remove any of these devices.	F 688		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for 1 of 1 (R17) resident reviewed who had post-traumatic stress disorder (PTSD). Findings include: R17's quarterly Minimum Data Set (MDS) dated 3/21/23, identified intact cognition, required supervision with most activities of daily living (ADLs). R17's diagnoses included PTSD, adjustment disorder, and depression. R17's care plan dated 12/28/22 lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization related to PTSD. During an interview on 6/26/23 at 12:43 p.m., R17 indicated he had a diagnosis of PTSD however	F 699	Little Falls Health Services was found to have failed to comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for a resident who has post-traumatic stress disorder. Inadequate practices were found under the following circumstances; R17's diagnoses included PTSD, adjustment disorder and depression. R17's care plan lacked individuated trauma informed approaches or intervention and lacked identification of triggers. Resident was interviewed for a Trauma-Informed Assessment identifying stressors related to PTSD diagnosis as well as triggers associated with that diagnosis. Care plan was updated regarding the findings and staff were educated on triggers noted. EHR was updated with findings to ensure nursing staff monitor for triggers and are aware of interventions of how to deescalate if they present.	8/28/23

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F 699	Continued From page 20 did not like to discuss this with others as he was a private man. During an interview on 6/29/23 at 9:15 a.m., nursing assistant NA-B stated she was not aware of any current residents that had PTSD. During an interview on 6/29/23 at 10:02 am., registered nurse (RN)-A did not think the facility had an assessment that addressed trauma informed care for a resident with PTSD. RN-A stated the social services designee (SSD) would know more about residents that had past trauma. During an interview on 6/29/23 at 10:17 a.m., with SSD, director of nursing (DON) and quality nurse consultant (QNC), SSD stated she would complete an admission interview with each resident that asked about past trauma. SSD stated R17 should have been interviewed by the previous SSD but could not find documentation that R17 had been. -QNC stated the facility had a trauma informed care questionnaire that should be completed upon admission. QNC stated R17's care plan should have included behavior monitoring, PTSD triggers, how staff would avoid those triggers and interventions to be used if R17 was triggered. -DON confirmed R17 was not assessed for trauma informed care, did not have behavior monitoring or a care plan that addressed R17's past trauma. A facility policy trauma informed care dated 1/6/20, indicated the facility would provide guidance to care center staff on the principles and care practices that guide trauma informed care that accounted for residents' experiences and preferences to eliminate or mitigate triggers	F 699	Potential of this occurring with other residents regarding trauma-informed care. DON or designee to review care plans and trauma informed care assessments of current residents. Care plans to be updated with findings and staff education to be completed if PTSD conditions are noted. Appropriate care planning to be initiated and reviewed to ensure triggers are avoided. All future admissions will be assessed for trauma-informed care with appropriate care planning and interventions placed upon the need. Policies were reviewed; showing no changes to be needed. Education to be provided to all staff on trauma informed care at next staff meeting. Education to be completed with staff regarding the need to identify triggers and implement interventions if presented. DON or designee to complete audits 3x/week for 4 weeks, then 1x/ week for 4 weeks. Audits to reflect review of diagnosis. care plans and trauma informed assessments. If PTSD is present diagnosis, DON or Designee to ensure appropriate care planning and assessments have been completed as well as interventions implements to deescalate triggers associated with diagnosis. Results of audits with be brought to QAPI for review for further recommendations for monitoring. Completion date 8/28/23.	

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F 699	Continued From page 21 that may cause re-traumatization of the resident.	F 699		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 755	Little Falls Health Services was found to	8/12/23

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F 755	Continued From page 22 review, the facility failed to ensure supply and administration of ordered medication for 1 of 5 resident (R19) reviewed for pharmacy services. Findings include: R19's quarterly Minimum Data Set (MDS) dated 5/2/23, indicated intact cognition, required extensive assistance with most activities of daily living (ADLs). Diagnoses included epilepsy, heart failure, diabetes, and depression. R19's current physician orders indicated an order for Keppra 500 mg three times daily for diagnosis of epilepsy. During an interview on 6/26/23 at 12:54 p.m., R19 stated she had not received her Keppra for a few days and did not know why. During observation and interview on 6/27/23 at 8:44 a.m., trained medication aide (TMA)-A administered R19's morning medications which included Keppra 500 mg. R19 asked TMA-A why she had not received her Keppra over the weekend. TMA-A explained R19 had not received the noon dose of Keppra for a few days because it had not been delivered from the pharmacy. TMA-A stated on 6/22/23 the medication cycle fill from the pharmacy provided two (morning and bedtime) medication cards of Keppra but should have provided three cards because R19 received Keppra three times a day. TMA-A stated she notified the registered nurse (RN) and the pharmacy of the missing card and requested it be delivered. During an interview on 6/27/23 at 9:20 a.m., licensed practical nurse (LPN)-A and TMA-A	F 755	have inadequate practice for failure to supply and administer ordered medications. Inadequate practices were found under the following circumstances: R19 was prescribed for Keppra 500mg to be administered po TID. Medication error occurred due to pharmacy not delivering medication and staff not following up; noon doses of Keppra were not administered for dates 6/23/23-6/26/23. Medication error was presented to the Medical Director with no new orders. Resident remained free from adverse reactions due to error. Education was completed with the appropriate staff regarding medication error; pharmacy delivered medication 6/27/23. Potential of this occurring with other residents regarding medication administration and potential for missing scheduled medications per Physician Orders. All resident medications were audited to ensure no additional errors occurred; no additional medications were missed. Education to be provided to all TMA and Nursing staff regarding medication administration and proper procedures if appropriate dose is not available. Review of ordering medications from pharmacy is to be completed and education to be done regarding notifying Provider if medication/dose cannot be obtained. Education to be completed at monthly nurses meeting; to be completed by 8/15/23 . Policies and procedures were reviewed; no changes required at this time. DON or designee to complete audits 3x /	

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F 755	Continued From page 23 reviewed medication administration record (MAR) to determine how many noon doses of Keppra R19 had missed. The MAR indicated R19 had not received the noon dose of Keppra on 6/23/23 and 6/24/23 and had received the noon dose of Keppra on 6/25/23 and 6/26/23 but when LPN-A counted the number of Keppra pills on the medication cards, no additional doses had been punched out for administration on 6/25/23 and 6/26/23. LPN-A stated R19's MAR did not accurately reflect the missed doses of Keppra. During an interview on 6/27/23 at 3:24 p.m., RN-A stated when a medication was not available the nurse on duty would notify the pharmacy and request it be delivered as soon as possible. RN-A stated If a resident had more than one card of the medication the staff should have used those cards to administer the medication to ensure the resident did not miss any doses. RN-A stated R19 did not have any adverse effects related to the missed doses and R19's physician was notified by the director of nursing (DON). During an interview on 6/27/23 at 3:45 p.m., DON confirmed that R19 had one card of Keppra that was not received during the recent pharmacy cycle fill and TMA-A had notified the nurse and ordered it from the pharmacy. DON stated she filled out a communication note for the nurse practitioner (NP) and requested the noon dose of Keppra to be held until the pharmacy delivered the missed card. DON stated she had not thought of having the staff utilize the other two cards of Keppra for the noon dose to ensure R19 did not miss any doses. DON stated the NP did not receive the communication note until today (6/27/23) and at that time the NP was updated on the omission of the noon dose of Keppra 500 mg	F 755	week for 4 weeks, then 1x / week for 4 weeks. Audits to reflect review of medication administration / missed medications and to review the reasoning and end result of these outcomes. Educations to be completed with staff who do not follow protocol put in place during staff meeting as listed above. Results of audits will be brought to QAPI for review for further recommendations for monitoring. Completion date of 8/28/23 .	

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F 755	Continued From page 24 from 6/23/23 through 6/26/23. DON stated going forward she expected that staff would utilize the additional medication cards of the same medication to ensure no missed doses occurred. - Medication/treatment error physician communication document dated 6/27/23, indicated no new orders resulting from medication error. A facility policy medication errors dated 7/2/14, indicated residents would receive medication in accordance with their physician's order and in compliance with state and federal regulations.	F 755		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by:	F 825		8/28/23

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F 825	Continued From page 25 Based on observation, interview and document review, the facility failed to provide occupational therapy as ordered for 1 of 2 residents (R15) reviewed for therapy services. Findings include: R15's annual Minimum Data Set (MDS) dated 5/23/23, identified severe cognitive impairment. R15 was dependent on staff for all ADL's. Diagnoses included post-concussional syndrome (persistence of various symptoms such as headache, dizziness, problems with concentration and memory weeks after a mild head injury), dysphagia (difficulty swallowing) and contracture (permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen) of left wrist. R15's care plan dated 8/26/22, indicated R15 had a decline in ROM (range of motion) related to Dementia and accident history as evidenced by non-ambulatory, decreased movement in all extremities. During observation on 6/27/23 at 11:44 a.m., R15 had a rolled washcloth that was placed in left hand, between his thumb and pointer finger with the remaining three fingernails pushing into palm. During observation on 6/27/23 at 2:28 p.m., R15 did not have a rolled washcloth in left hand. Fingernails were pushing up again the inside of resident's palms leaving indentations. During interview on 6/26/23 at 6:26 p.m., R15's wife stated R15 was supposed to be evaluated for a splint that would go in R15's left hand to help with the contracture as the rolled washcloth is not	F 825	Little Falls Health Services was found to have failed to provide Occupational Therapy services as ordered. Inadequate practices were found under the following circumstances: R15 was found to have noted decline in ROM to left hand. Orders were requested and obtained for an evaluation to take place for a splint to this hand due to noted contractures; obtained 5/18/23. As of 6/27/23, resident had not yet been evaluated by therapies. Resident was evaluated for OT services on 7/17/23 and it was found that splints for bilateral hands would be required. Splints were ordered for resident and alternative options ('carrots') were used at this time to prevent further troubles with contractures and to promote skin integrity while facility waited for delivery of splints. Staff were educated on the use of splints and images were placed in residents' room for a visual of how splints are to be applied. Care plan and group sheets were updated to reflect changes to care. Potential of this occurring with other residents regarding inconsistency and incompletion of therapy evaluations. All additional orders for therapy services for residents were reviewed to ensure evaluations were completed and or scheduled for completion. All therapy orders will be tracked by the Director of Nursing or designee regarding the date that orders were requested and the date the evaluations were completed. Education to be provided to Big Stone Therapy staff regarding expectations of timely evaluations. Education to be	

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F 825	Continued From page 26 always placed and when it is placed, it is not always in the correct position. During record review, occupational therapy was ordered on 5/18/23 to evaluation and treat. Order identified, "OT eval and treat. Needs hand splints due to contractures and ROM." R15 had not yet been seen by OT for evaluation. During interview on 6/29/23, at 1:01 p.m., registered nurse (RN)-C stated when facility thinks that a resident need therapy services, facility reaches out to the provider to receive an order. Once order is received, a therapy form is completed and put in therapy's mailbox. RN-C indicated they have started to email the therapy form to therapy as well so there is a paper trail. RN-C stated that her expectations is for the resident to be seen by OT/PT the week they receive the referral from the provider. RN-C indicated that some referrals to OT/PT have been sitting there for one to two months before seen by therapy. RN-C stated R15's order for OT was received when she out for surgery. When RN-C returned from leave, R15 was on the therapy list to be seen and facility has just been waiting for therapy services. During interview on 6/29/23 at 3:05 p.m., physical therapist assistant (PTA) stated the process for an OT/PT referral is that therapy received a referral from the facility in their mailbox. PTA then runs the insurance and schedules an OT/PT appointment for resident. PTA stated their policy indicates that resident should be seen in three to five days of the referral, but is could be up to 2 weeks or longer due to being short-staffed. PTA stated that she has not received the OT referral for R15.	F 825	completed with staff regarding placement of splints for resident R15 as well as placement of splints for additional residents. EHR is to be updated to reflect placement of orders in the system for nursing to monitor for completion of placement of splints. If it is found that splints have not been placed per orders, education will be completed with appropriate staff. If it is found that therapy evaluations have not been completed in a timely manner, the findings will be brought forward to site coordinator for further review. Policies and procedures were reviewed, no needed adjustments at this time. DON or designee to complete audits 3x / week for 4 weeks, then 1x / week for 4 weeks. Audits to reflect the completion of therapy evaluations, to determine if evaluations have been completed timely as well as audits to ensure placement of splints are completed per orders. Findings with therapy evaluations will be brought forward to site coordinator for further review if deficits are noted. Educations to be completed with staff if splints have not been placed per orders. Results of audits will be brought to QAPI for review for further recommendations for monitoring. Completion date of 8/28/23.	

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F 825	Continued From page 27	F 825		

During interview on 6/29/23 at 3:33 p.m., the director of nursing (DON) stated that when an OT/PT referral is received, order is processed, and a copy is put in therapy's mailbox. DON stated they also just started to email a copy to therapy so that there is documentation of referral being sent. DON stated they also started addressing therapy anticipated evals at their daily interdisciplinary meetings (IDT) to remind them of what is still sitting out there for the facility to follow up with therapy on where the process is and the anticipated appointment window. DON indicated that her expectations for therapy to see resident from time of referral would depend on what the order is being requested for, if it were for safety, she would expect in the week that order was received.

The facility policy Therapy Screening dated 9/2008 with a revision date of 10/2022, indicated a rehabilitation screen shall be completed on each new resident admitted to the facility, with a readmission, quarterly with the weekly care plan meetings and as needed by the resident's change in functional status or safety. The rehabilitation screen is a brief professional review of the resident by observation, by review of the medical record, or by interview of the patient, facility staff, or family member. It is responsibility of the rehabilitation team to keep updated on required screens, develop effective communication with the facility personnel, educate facility staff as to the role and benefit of rehabilitation services, educate nursing in the need for documentation supporting the noted decline in the patient's function or deficits triggering the referral/needs for rehabilitation services.

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F 883	Continued From page 28	F 883		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		8/28/23

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F 883	Continued From page 29 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R28, R42,R5, R8) were offered or received the pneumococcal vaccine (PCV20) in accordance with the Centers for Disease Control (CDC) recommendations. Findings include: The CDC's PneumoRecs VaxAdvisor identified: "Based on shared clinical decision-making, decide whether to administer one dose of PCV20 at least 5 years after the last pneumococcal vaccine dose" and patients age 19-64 with the risk factor of diabetes mellitus are recommended to have "one dose of PCV15 or PCV20 at least 1 year after their last dose of PPSV23". The CDC's Pneumococcal Vaccine Timing for Adults identified:	F 883	Little Falls Health Services was found to have failed to ensure residents were offered or received the Pneumococcal Vaccine (PCV20) in accordance with the Center for Disease Control recommendations. Inadequate practices were found under the following circumstances: residents R28, R42, R5 and R8 were found to not have been offered or received the PCV20 Vaccine per CHC recommendations. Residents were contacted for consent for PCV20 Vaccination and representatives were contacted for consent for those unable to make own decisions. The resident immunization policy and SHO were updated with new recommendations. Potential of this occurring with other residents; Little Falls Health Services will identify qualifying residents to vaccinate	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 30 "Together with the patient, vaccine providers may choose to administer PCV20 to adults 65 years and older who have already received PCV13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of 65 years old". R28's facesheet dated 6/29/23, identified he was 60 years old, had a diagnosis of Type 2 diabetes mellitus and admitted 9/10/18. R28 had no allergies to vaccines or contraindications to the PCV20 vaccine listed. R28's immunization report identified he had previously received the PPSV23 on 1/19/17. R28's medical record lacked evidence the recommended PCV20 vaccination was offered or received. R42's face sheet dated 6/29/23, identified he was 82 years old and admitted on 6/28/21. R42 had no allergies or contraindications to the PCV20 vaccine listed. R42's immunization report identified he had previously received the PCV13 on 1/27/16 and the PPSV23 on 8/26/10 and 1/3/08. R42's medical record lacked evidence the recommended PCV20 vaccine was offered or received. R5's facesheet dated 6/29/23, identified she was 74 years old and admitted on 11/08/18. R5 had no allergies or contraindications to the PCV20 vaccine listed. R5's immunization report identified she had previously received the PCV13 on 10/9/15 and the PPSV23 on 2/13/08 and 11/30/12. R5's medical record lacked evidence the recommended PCV20 vaccine was offered or received. R8's face sheet dated 6/29/23, identified she was 102 years old and admitted on 2/27/21. R8 had no allergies or contraindications to the PCV20	F 883	these said residents to be up to date with the recently revised pneumococcal 20 vaccine schedule. All qualifying residents will be identified via the CDC PneumRecsVaxAdvisor system. All qualifying residents or their representative will be contacted to obtain consent or declination. Education to be completed with residents/family/representatives that decline the vaccine. Consents/declinations to be obtained by 8/28/23. Policies and procedures were reviewed, no needed adjustments at this time. DON or designee to complete audits 3x / week for 4 weeks, then 1x / week for 4 weeks. Audits to reflect review of vaccination status for all future admissions to ensure they are up to date on Pneumococcal vaccinations and to ensure that the PCV20 was offered. Results of audits will be brought to QAPI for review for further recommendations for monitoring. Completion date of 8/28/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 883	Continued From page 31 Vaccine listed. R8's immunization report identified she had previously received the PPSV23 on 12/6/02 and 12/2/05. R8's medical record lacked evidence the recommended PCV20 vaccine was offered or received. When interviewed on 6/29/23 at 1:07 p.m., the facility's infection preventionist registered nurse (RN)-B stated in order to determine a resident's eligibility for vaccinations "the admission coordinator reviews vaccine history upon admit". RN-B stated "After admission we send the resident's information to the pharmacy who I assumed was tracking resident vaccine eligibility." When interviewed on 6/29/23 at 1:32 p.m., director of nursing (DON) stated upon admission a resident's record is reviewed for vaccine eligibility. The DON stated after determining if a resident is eligible for a vaccination "the facility is supposed to offer it, obtain an order, educate on risk/benefit and obtain consents or declinations". The facility policy Resident Immunizations dated 12/2/22, identified "Pneumococcal vaccines will be offered to each resident according to the current recommendations from the CDC."	F 883		

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	245399	A. BUILDING **03 - EAST BUILDING** B. WING ______	**06/28/2023**

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K 000	INITIAL COMMENTS	K 000		

An annual Life Safety recertification survey was conducted on 06/28/2023, 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/09/2023

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
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K 000	Continued From page 1 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A 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	K 000		

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	245399	A. BUILDING **03 - EAST BUILDING** B. WING ________	**06/28/2023**

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K 000	Continued From page 2 (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. The facility has a capacity of 64 beds and had a census of 57 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1, 7.9.3.1, and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/28/2023 at 10:00 AM, it was revealed by a review of available documentation that the facility could not provide documentation showing that the annual emergency lighting had been completed	K 291	RE: MN State Fire Marshall K-tag 0291 for Little Falls Health Services. Reference: NFPA 101 (LSC 2012) Existing Health Care - Emergency Lighting The Little Falls Health Services skilled nursing facility was found to have inadequate documentation for the emergency lighting. The documentation indicates that the emergency lighting annual test had not been completed for 2 emergency lights in building #3.	8/12/23

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K 291	Continued From page 3 for 3 emergency lights in Building 3. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	K 291	Plan of correction will be as follows for all Emergency Lighting: • An “M” will indicate the months in which inspections take place for the required 30 second monthly test. • An “A” will indicate the month in which inspections take place for the required 90-minute, once annual test. As a best management practice and quality control measure, the Environmental Services Director will conduct the next 3 months of emergency light inspections, one of which will include the required annual (“A”), 90-minute test. The record of testing will be reviewed with the Administrator to ensure the document has the proper monthly vs. annual symbolism to identify the two separate tests, respectively.	