CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: W5XP

${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PAKI	1 - 10 BE COM	LTETED BA I	HE STATI	E SURVEY AGENCY	Facility ID: 00382
MEDICARE/MEDICAID PROVIDER NO. (L1) 245399 2.STATE VENDOR OR MEDICAID NO.		3. NAME AND ADD (L3) LITTLE FAI (L4) 1200 FIRST	LLS CARE CEN	ΓER		4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 087497000		(L5) LITTLE FAI	LLS, MN		(L6) 56345	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNER (L9) 01/01/2014	SHIP	7. PROVIDER/SUI	PPLIER CATEGOR 05 HHA	Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 12/28/20 8. ACCREDITATION STATUS:	(L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:	:		
From (a): To (b):		X A. In Complian Program Re Compliance	quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF)	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	32 (L18)				5. Life Safety Code	9. Beds/Room
13. Total Certified Beds	32 (L17)		pliance with Program and/or Applied Waiv		* Code: A *	(L12)
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF 18/19 SNF 32	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE S	SHOW LTC CANCELL	LATION DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PROVAL Date:
Kathy Lucas, Unit	Superviso	or	12/28/2016	(L19)	Kate JohnsTon, Pro	ogram Specialist 01/24/2017 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR SINGLE STAT	TE AGENCY
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Particip 2. Facility is not Eligible	ate (L21)		IPLIANCE WITH C	CIVIL	 21. 1. Statement of Financ 2. Ownership/Control I 3. Both of the Above : 	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	24. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 12/01/1986	BEGINNING	DATE	ENDING DAT	Е	VOLUNTARY 000 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 2	7. ALTERNATIV				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	TE	Posted 01/30/2017 Co.	
	(L32)	12/15/2016		(L33)	DETERMINATION APPRO	VAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245399 January 24, 2017

Ms. Amy Walker, Administrator Little Falls Care Center 1200 First Avenue Northeast Little Falls, MN 56345

Dear Ms. Walker:

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

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

Effective December 13, 2016 the above facility is certified for or recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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.

Little Falls Care Center January 24, 2017 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 24, 2017

Ms. Amy Walker, Administrator Little Falls Care Center 1200 First Avenue Northeast Little Falls, MN 56345

RE: Project Number S5399027

Dear Ms. Walker:

On November 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 3, 2016. This survey found the most serious deficiencies 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) whereby corrections were required.

On December 28, 2016, 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 November 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 3, 2016, effective December 13, 2016 and therefore remedies outlined in our letter to you dated November 22, 2016, 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.

Little Falls Care Center January 24, 2017 Page 2

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

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P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	Т
IDENTIFICATION NUMBER	A. Building			
245399 _{Y1}	B. Wing	Y2	12/28/2016	Y3
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).

ITE	M		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0272		Correction	ID Prefix	F0279		Correction	ID Prefix	F0280		Correction
Reg. #	483.20(b)(1)		Completed	Reg.#	483.20(d), 483.20(k)(1)	Completed	Reg.#	483.20(d)(3), 483. (2)	.10(k)	Completed
LSC			12/13/2016	LSC			12/13/2016	LSC			12/13/2016
ID Prefix	F0282		Correction	ID Prefix	F0309		Correction	ID Prefix	F0311		Correction
Reg.#	483.20(k)(3)(ii)		Completed	Reg.#	483.25		Completed	Reg. #	483.25(a)(2)		Completed
LSC			12/13/2016	LSC			12/13/2016 	LSC			12/13/2016
ID Prefix	F0314		Correction	ID Prefix	F0318		Correction	ID Prefix	F0322		Correction
Reg. #	483.25(c)		Completed	Reg. #	483.25(e)(2)	Completed	Reg. #	483.25(g)(2)		Completed
LSC			12/13/2016	LSC			12/13/2016 	LSC			12/13/2016
ID Prefix	F0441		Correction	ID Prefix	F0465		Correction	ID Prefix			Correction
Reg.#	483.65		Completed	Reg.#	483.70(h)	Completed	Reg. #			Completed
LSC			12/13/2016	LSC			12/13/2016	LSC			-
ID Prefix			Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #			Completed	Reg. #			Completed
LSC				LSC				LSC			-
REVIEWE STATE AC		REVIEWE (INITIALS		DATE 01/24/2	2017	SIGNATURE OF S		8202		DATE	12/28/2016
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE				DATE	
FOLLOW 11/3/201	UP TO SURVEY C	OMPLETED	ON			ANY UNCORRECT ED DEFICIENCIES				YE:	s 🗆 no

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: W5XP

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PAR	Г I - ТО ВЕ СОМ	PLETED BY T	HE STAT	E SURVEY AG	ENCY	Fa	acility ID: 00382
MEDICARE/MEDICAID PROVIDE (L1) 245399 2.STATE VENDOR OR MEDICAID N (L2) 087497000		3. NAME AND AD (L3) LITTLE FAI (L4) 1200 FIRST A (L5) LITTLE FAI	LLS CARE CENT AVENUE NORTI	ΓER	(L6) 56345		4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 01/01/2014		7. PROVIDER/SUI	PPLIER CATEGORY 05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Cor	9. Other mplaint
6. DATE OF SURVEY 11 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Oth	/03/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 1	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SP 32 (L37) (L38) 16. STATE SURVEY AGENCY REM.	32 (L18) 32 (L17) WN NF 19 SNF (L39)	B. Not in Com Requirements ICF (L42)	nce With quirements Based On: Acceptable POC ppliance with Program and/or Applied Waiv IID (L43)		2. Tech 3. 24 H 4. 7-Da	nical Personnel four RN ty RN (Rural SNF) Safety Code	Following Requirements:	cor
7. SURVEYOR SIGNATURE Date: Jennifer Bahr, HFE NE II 12/02/2016 Kate JohnsTon, Program Specialist 12/13/2016 (L20)								
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE OR S	SINGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBIE 1. Facility is Eligible to 2. Facility is not Eligible.	Participate		IPLIANCE WITH C	IVIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	-1513)
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATI (L25)		26. TERMINAT VOLUNTARY 01-Merger, Closu 02-Dissatisfaction	_00		eet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involut 04-Other Reason f	•	OTHER 07-Provider S 00-Active	Status Change
			(L45)					
28. TERMINATION DATE:	(L28)	03001	CARRIER NO.	(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	(L32)	2. DETERMINATION (OF APPROVAL DAT	ΓΕ (L33)	Posted 12/	15/2016 Co.	S/A Y	
	(L34)			(L33) I		OLION APPROV	VAL.	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 22, 2016

Ms. Amy Walker, Administrator Little Falls Care Center 1200 First Avenue Northeast Little Falls, MN 56345

RE: Project Number S5399027

Dear Ms. Walker:

On November 4, 2016, 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:

Kathy Lucas, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338

Fax: (320)223-7348

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 13, 2016, 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 February 3, 2017 (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 May 3, 2017 (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 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: 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 12/02/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION	` '	E SURVEY IPLETED
		245399	B. WING			11/	03/2016
	PROVIDER OR SUPPLIER	3		1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	INITIAL COMMENT The facility's plan of as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electronibe used as verificated An investigation of completed and four Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.20(b)(1) COMFASSESSMENTS The facility must conduct a comprehensive, a reproducible assess functional capacity. A facility must make assessment of a reresident assessment of a reresident assessment by the State. The aleast the following: Identification and do Customary routine; Cognitive patterns; Communication;	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will tion of compliance. complaint H5399021 was not not to be substantiated. acceptable electronic POC, an our facility may be conducted to antial compliance with the en attained in accordance with the en attained in accordance with en attained in accordance with en accurate, standardized sment of each resident's e a comprehensive sident's needs, using the not instrument (RAI) specified assessment must include at emographic information;	F C		CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
I ABORATORY	Vision; Mood and behavior Psychosocial well-b		NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 12/02/2016

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245399	B. WING		11/	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CO 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentia Documentation of the additional asse areas triggered by Data Set (MDS); a	g and structural problems; and health conditions; nal status; and procedures; l; summary information regarding ssment performed on the care the completion of the Minimum	F 2	272		
	by: Based on interview facility failed to conuse of psychotropic during the assessment 2 of 5 residents (Runnecessary median Findings include: R9's admission Min 10/16/16, indicated dementia, anxiety of MDS also indicated the last seven days medication the last	NT is not met as evidenced v and document review, the aprehensively assess for the c (mood altering) medication ment reference dates (ARD) for 9, R44) reviewed for cations. Inimum Data Set (MDS) dated I R9 had diagnoses of disorder and depression. The d R9 was taking an antianxiety and antidepressant seven days. R9's psychotropic a Assessment (CAA) was		LFHS conducts comprehens assessments of each resident on admissio and with a significant change. R#9- a comprehensive psychassessment was completed. R#44- a comprehensive psychrug assessment was completed. All residents taking psychotromedications have a potential affected by a deficient practicarea.	n, annually notropic drug chotropic eted. opic to be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		245399	B. WING		11/0	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3	1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 272	initiated, however, twas never completed 10/1 comprehensive psy R44's significant chindicated R44 had anxiety disorder an indicated R9 was ta seven days, an anti and antidepressant days. R9's psychotrinitiated, however, twas never completed R44's General Nurs facility documents to started 10/19/16, and contain a compreheassessment. During interview on registered nurse (Paresponsible for compession of R9 and Paresponsible for R9 and	the assessment worksheet ed. servations (where the facility hission CAAs started 10/9/16, 14/16, did not contain a vehotropic drug assessment. ange MDS dated 10/19/16, diagnoses of dementia, d depression. The MDS also aking an antipsychotic the last fanxiety the last seven days medication the last seven ropic drug use CAA was the assessment worksheet ed. ses Observations (where the he CAAs after admission) and completed 10/19/16, did not ensive psychotropic drug 11/3/16, at 2:25 p.m. 1N)-C stated that she was appleting the MDS on the lated that she did not do a lase CAAs during the ARD at CAAs during the ARD at CAAs during the ARD at CAAs during the assessment is during the first week of the last the ARD period. However,	F 272	All Nursing staff involved in writin med assessment were re-educat process of completing psychotron medication assessments. All other residents receiving a psychotropic medication will have psychotropic medication assessments completed. DON or designee will audit Comprehensive psychotropic meassessments to ensure they are completed timely. A minimum of per week for 2 weeks, then 2 aud x2 weeks, then once weekly for 2 and then monthly thereafter. Audit results will be brought to the committee for review and further recommendation. Completion date for F 272 is: 12/	ed on oic e a nent dication 3 audits dits/week weeks e QAPI	

AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG	TRUCTION		OMPLETED
		245399	B. WING				1/03/2016
NAME OF PROVIDER		3		1200 FIR	ADDRESS, CITY, STATE, ZIP CODE ST AVENUE NORTHEAST FALLS, MN 56345		
	CH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
facility i warrant utilize the electror assess observation observa	ted. RN-C all he workshee hic MDS recoments under ations. Interview on a for nursing section of nursing section of nursing section of nursing section of nursing section, annual section, and time annual section, and time annual section of the plan must be plan must b	what medications were so stated the facility does not est provided with the facility's ord but rather documents the radmission or general nursing 11/3/16, at 4:01 p.m. the stated a comprehensive vehotropic drug use was apleted on admission, annually not change MDS. sychotropic Medications dated dress a comprehensive be completed during or significant change MDS. (1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's	F2				12/13/16

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURV COMPLETER	
		245399	B. WING		11/0	03/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 279	§483.10, including under §483.10(b)(a) This REQUIREME by: Based on observareview, the facility comprehensive care continuous positive breathing machine used a CPAP. In a develop a comprel included range of a 1 residents (R23) approgram. Findings include: R40's Face Sheet R40's diagnoses in failure with hypoxia oxygen reaching the spontaneous pneu pulmonary disease unspecified, obstruwhere a person habreathing or shallon R40's quarterly Mit 10/24/16, indicated	the right to refuse treatment 4). INT is not met as evidenced ation, interview and document failed to develop a re plan for the use of a re plan for the use of a re airway pressure (CPAP) of for 1 of 1 resident (R40) who addition, the facility failed to mensive care plan which motion (ROM) services for 1 of reviewed for a restorative reviewed for a restorative a (deficiency in the amount of the body's tissues), primary mothorax, chronic obstructive recommendation (ROPD) active sleep apnea (a disorder as one or more pauses in w breathing while sleeping).	F 2	LFHS develops comprehe plans to describe services maintain the resident's high physical, mental and psychwell-being. R#40- care plan and NAR were updated to include Chelaced when resident requestive ROM Program. All residents on CPAP and ROM have the potential to a deficient practice in this at Nursing staff involved care documentation were re-eduprocess of completing a care CPAP and restorative ROM Care plans for residents with ROM programs and who us reviewed and revised prn.	to attain or nest practicable losocial group sheets PAP to be ests. ed to include a that receive be affected by area. plan ucated on the line plan for for programs. It a restorative se CPAP were	
	R40's care plan da at risk for shortnes directed nursing st (HOB), monitor for	dized oxygen (O2) therapy. ated 3/06/16, identified R40 was as of breath (SOB), and aff to elevate head of bed SOB, and maintain O2 at 3-4 anula. The care plan lacked		DON or designee will perform to ensure care plans are as CPAP and Restorative Romminimum of 3 audits per with weeks, then 2 audits/week once weekly for 2 weeks as monthly thereafter.	ccurate for n programs. A eek for 2 x2 weeks, then	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		STREET ADDRESS, CITY, STATE 1200 FIRST AVENUE NORTHE LITTLE FALLS, MN 56345	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 279	R40 was to have C a day (day, evening bed. During interview on member (F)-A state should be on when R40 was observed cannula at 3 liters on hight stand. During observations 11/1/16, at 6:50 p.m was in bed sleeping cannula on and CP. During interview on registered nurse (R should be on the cannula be on the cannula on the cannula on the cannula on the cannula be on th	lers dated 10/04/16, indicated PAP machine applied 3 times in, night) and anytime lying in 10/31/16, at 1:37 p.m. family at R40's CPAP machine he was sleeping or napping. sleeping with O2 per nasal in, and CPAP sitting on R40's is on 10/31/16, at 2:25 p.m., n., 11/2/16, at 7:10 a.m., R40 in with HOB elevated, O2 nasal AP on nightstand. 11/02/16, at 9:49 a.m. N)-A stated R40's CPAP are plan. 11/03/16, at 11:00 a.m. DON) stated R40's CPAP are plan. S dated 10/5/16, identified cognitive impairment and no in ROM in both upper and 11/2/16, at 12:07 p.m. PT)-A stated R23 had received was admitted to the facility and	F 27	Audit results will be brocommittee for review a recommendation. Completion date for 27	nd further	

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F 279	nursing program (Funder the program. R23's care plan daineeding assistance R23 as being on a receiving ROM. During interview on stated R23 was too days a week. RN-Awere assessed quantursing assistant ground puring interview on stated she was in the care plans to reflect	ied R23 was on a restorative (NP) but did not list ROM ded 1/31/16, indicated R23 with mobility. It did not identify restorative program or 11/3/16, at 1:38 p.m. RN-A receive ROM once a day six stated R23's ROM abilities arterly along with updating the roup sheets and care plan. 11/3/16, at 3:55 p.m. RN-C ne process of updating the trestorative programs. RN-C plan did not contain a	F 2	79		
F 280 SS=D	stated she would exprogram to be on the A facility policy entition 11/8/15, directed responded to the carnurse manager. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under the control of the carnurse manager.	cled Range of Motion, reviewed storative ROM programs will re plan and care guide by the O(k)(2) RIGHT TO NNING CARE-REVISE CP right, unless adjudged erwise found to be the laws of the State, to ing care and treatment or	F 2	80		12/13/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		STREET ADDRESS, CITY, STATE, ZIP COD 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
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F 280	within 7 days after comprehensive ass interdisciplinary tea physician, a registe for the resident, an disciplines as deter and, to the extent p the resident, the re legal representative	are plan must be developed the completion of the sessment; prepared by an arm, that includes the attending ared nurse with responsibility dother appropriate staff in armined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after	F 2	30		
	by: Based on observareview, the facility of the presence of deresidents (R7) reviews Findings include: R7's annual Minimary/22/16, indicated of problems. Facility General Nudated 5/10/16, indicated of the facility General Nurses's Cry22/16 and 8/19/10 lower dentures, how missing.	NT is not met as evidenced tion, interview, and document ailed to revise the care plan for ntures/natural teeth for 1 of 3 ewed for dental services. The provided HTML is a service of the care plan for ntures/natural teeth for 1 of 3 ewed for dental services. The provided HTML is a service of the care plan for no dental services. The provided HTML is not a service of the care plan for no dental concerns or the care plan for no dental concerns or expected HTML is not a service of the care plan for no dental services. The provided HTML is not a service of the care plan for no dental services. The provided HTML is not a service of the care plan for no dental services.		LFHS ensure the resident's or reflected on the individual plant. R# 7 care plan and NAR group updated to reflect the absence teeth or dentures. All residents' care plans were ensure the care plan reflects the status and oral hygiene needs. Nursing staff were re-educated assessing oral status and prodinform Nurse Manager who is updating care plans. DON or designee will perform audits to ensure care plans regresident's oral status are companimum of 3 audits per week weeks, then 2 audits/week x2	of care. o sheet was of natural reviewed to neir oral d on the sess to in charge of care plan garding the olete. A for 2	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		COMPLETED			
		245399	B. WING			11/	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		12	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST ITTLE FALLS, MN 56345		
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F 280	10/20/16, indicated missing for months natural teeth. An undated, un-title group sheet, identifithe top of her mouther teeth. R7's current care p directed staff to bruand to clean R7's down and the clean R7's care plan had the control of the clean R7's care plan had the clean R7's care plan	R7's dentures had been and indicated R7 had no ed facility nursing assistant ied R7 had partial dentures on hand directed staff to brush lan, last revised 8/14/16, sh R7's own existing teeth entures overnight. on 10/31/16, at 2:22 p.m. R7 eth or dentures in her mouth. evation on 11/1/16, at 6:14 p.m. tulous while eating supper. NA)-D assisted R7 to eat and rear dentures and had no ear dentures and had no 11/2/16, at 8:19 a.m. NA-I es refused oral cares but tural teeth. NA-I looked at an e sheet to confirm R7 had 11/2/16, at 8:50 a.m. licensed N)-A stated R7 had natural		280	once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the committee for review and further recommendation. Completion date for F 280 is 12/13		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NG		(X3) DATE SURVEY COMPLETED	
		245399	B. WING		11/0	3/2016
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
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F 282 SS=D	stated the care planare made. During interview on director of nursing shave been updated teeth and denture shave been updated teeth and denture shave Manager to rin the electronic meaddition, communicateam. 483.20(k)(3)(ii) SEFPERSONS/PER CATHERSONS/PER CATHE	some point. 11/2/16, at 1:23 p.m. RN-C as were updated as changes 11/2/16, at 1:34 p.m. the stated the care plan should to reflect the change in R7's status. Iled Care Plans, last reviewed was the responsibility of the review and change care plans adical record (EMR) and, in the state changes to the nursing RVICES BY QUALIFIED ARE PLAN Iled or arranged by the facility y qualified persons in ach resident's written plan of the review, and document ailed follow the plan of care to with ambulation was provided	F 2	80	ded by	12/13/16
	with a restorative position provide services pressure ulcer for 1 pressure ulcers; an placement of a gas	(R23) reviewed for ambulation rogram; and the facility failed to relieve pressure to heel of 3 residents reviewed for d failed to (R2) check trostomy tube (G-tube) as e plan for 1 of 1 resident (R40)		Restorative and NAR staff caring #23 were re-educated on the residuant ambulation and ROM programs a documentation of the programs. NAR staff caring for R#2 were	dent's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245399	B. WING			11/0	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		12	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST ITTLE FALLS, MN 56345		
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F 282	who had a G-tube. Findings Include: R23's quarterly Min 10/5/16, identified a impairment and nerone person to walk R23's current care staff to walk R23 redecline in ambulation. An undated un-title group sheet, identifinursing program (FR23 to meals. During observation was seated in her work (NA)-D was observed R23's wheelchair at the dining room for was made to walk work made to walk as During observation.	nimum Data Set (MDS) dated a moderate cognitive eded extensive assistance of both in her room and outside. plan dated 1/31/16, directed esident in order to prevent a con. d facility nursing assistant fied R23 was on a restorative RNP) and directed staff to walk on 11/1/16, at 5:32 p.m., R23 wheelchair. Nursing assistant ed to put foot pedals onto nd proceeded to push R23 to supper. No attempt or offer	F 2	82	re-educated on the resident's prog providing pressure relief to heels a need to report refusals to the Nurse NAR Group sheets were reviewed revised to include current pressure program for heels and Restorative Ambulation and ROM programs. Nursing staff caring for R#40 were re-educated on checking placemer G-tube per facility policy and MD of All residents with G-tubes, pressur programs for heels and restorative programs have plans of care that in followed by staff caring for the resident on the availability of plans of care a need to follow the resident's specific of care. DON or designee will perform rand observational audits of Restorative and Amb programs. A minimum of audits per week for 2 weeks, then once we for 2 weeks and then monthly there.	and the e. and relief of a rders. e relief om the ic plan om ROM is 3 2 veekly eafter. om	
the nurse's station into the dining breakfast. During interview on 11/2/16, at 7:4 practical nurse (LPN)-E stated R2 restorative program but did not we		11/2/16, at 7:44 a.m. licensed N)-E stated R23 was on a			programs for heel pressure relief. minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weel once weekly for 2 weeks and then monthly thereafter.	2	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245399	B. WING			11/(03/2016
	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345				
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F 282	was seated in her vitransferred from the NA-G and NA-I. R2 be pushed in her witransferred from the NA-G and NA-I. R2 be pushed in her witransferred from the NA-G and NA-I. R2 be pushed in her witransfer witran	on 11/2/16, at 11:52 p.m. R23 wheelchair. R23 had been bed into the wheelchair by 3 was then observed to again heelchair to lunch. 11/2/16, at 12:02 p.m., NA-G used to walk to lunch. NA-G of ever walk to meals and was on a restorative ambulation 11/2/16, at 12:07 p.m. PT)-A stated R23 had received was admitted to the facility and ed with therapy for a restorative ambulation ed R23's goals was to t) to 50 ft at a time. 11/3/16, at 7:46 a.m. NA-H walk to meals before her her previous room was closer NA-H did not think R23 could m her current room to the bught staff could attempt to was closer to the dining room. 11/3/16, at 1:38 p.m. 11/3/16, at 1:38 p.m.	F 2	282	DON or designee will perform rand observational audits of checking G placement, A minimum of 3 audits week for 2 weeks, then 2 audits/we weeks, then once weekly for 2 weethen monthly thereafter. Audit results will be brought to the committee for review and further recommendation. Completion date for F 282 is 12/13.	-tube per eek x2 eks and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245399	B. WING			11/0	03/2016
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST ITTLE FALLS, MN 56345	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	of nursing (DON) s R23's ambulation p documentation err R2's 14-day sched 10/12/16, identified ulcers, had one sta unstageable press It also identified pr chair and bed, and repositioning progr R2's care plan date were to provide ex - Assistance with t in bed Assist of two to ta - Assistance of two - R2 had a pressur with an intervention mattress and to tu three hours Monitor for positic - Cushion to whee	n 11/3/16, at 4:16 p.m. director stated the inconsistency in program was due to ors by the nursing assistants. Ituled assessment MDS dated d R2 was at risk of pressure age 2 pressure ulcer and one sure ulcer, and none worsening. essure reducing device for the d R2 was on a turning and ram. ed 10/31/16, identified staff tensive assistance as follows: urning and repositioning when ake resident to the toilet. o staff for ambulation re ulcer to coccyx / low back, of an air mattress of an air rn and reposition every two to	F 2	282	DEFICIENCY)		
	mattress. During observation was lying in bed or were noted to be of floated.	es, float heels, and air n on 11/2/16, at 7:06 a.m. R2 n her right side. Both heels lirectly on the mattress, not n on 11/2/16, at 7:39 a.m. the					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 282	DON and RN-C endressing changes to right medial buttock R2's heels were not assisted to place a float the heels off the On 11/3/16, at 8:54 began. R2 was obtain the dining room, was observed in optic back half of the slip heel, resting on the of the foot rest. At the activity room, was observed in optic heel, resting on the of the foot rest. At the activity room, was observed in optic heel, resting on the of the foot rest. At the activity room, was observed in optic heel, resting on the staff dot. At 11: the activity room, a R2 asked to use the left foot. At 11: the activity room, a R2 asked to use the left foot offer to observed to reposit During interview on denied being aware When she helped to the pillow had been knees, and R2 did verified R2's heels mattress at this tim During interview on stated R2 has a number of the pillow had been knees, and R2 did verified R2's heels mattress at this tim	tered R2's room to perform to the pressure ulcers on her and left heel. RN-C stated to floated in bed. RN-C pillow beneath R2's legs to be bed. a.m. continuous observation served sitting in her wheelchair eating breakfast. R2's left foot bened back slipper, with the sper and foot, including the foot rest, and the front half off 9:56 a.m. R2 was assisted to ith left foot observed 28 a.m. R2 remained in the ffee. Activity director (AD) table, making no offer to adjust 10 a.m. AD assisted R2 out of and to her room. At 11:18 a.m. to bathroom, and NA-F entered us observation ended at this and 24 minutes, R2 remained with her foot observed with the foot rest. During this time, a reposition and R2 was not		282			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION DING	(X3)	(X3) DATE SURVEY COMPLETED	
		245399	B. WING			11/03/2016	
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F 282	floated that morning wound care, and we happens. RN-C stareport any changes the RNs. During interview on stated R2's heel sh the footrest, and stared received indicated where the well as identified the and services that me goals, and the frequence also indicated under nursing assistants as	g when she entered to do as not aware of how often this ated staff are expected to or non-compliance to one of 11/3/16, at 1:38 p.m. RN-C ould not be resting directly on aff education was provided. Care Plans, undated, e care plans can be found as e care plan includes the care plust be provided to meet those usency of these services. It er nursing responsibilities are to chart daily on resident o-to-date information on	F 2	282			
	check placement of medications via the orders R40's physician ord G-tube feeding Jev hour times 24 hours indicate he was to red-tube with 30 cubi before and after medications.	ted 6/16/16, directed nurses to f G-tube, administer G-tube following physician's der dated 10/4/16, directed ity 1.2 at 65 milliliters (ml) per s. R40's medication orders receive his medications via ic centimeters (cc) flushes edication. on 10/31/16, at 2:25 p.m.					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245399	B. WING		 	11/0	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		120	REET ADDRESS, CITY, STATE, ZIP CODE 00 FIRST AVENUE NORTHEAST TLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	LPN-A prepared to running in R40's G-syringe, placed it in water, withdrew 60 R40's G-tube port, wipe. LPN-A placed G-tube port and attracts of water, and matcheck for G-tube plauscultation prior to During interview on stated R40 had a G-tube placement prince of Jevity. During observation LPN-B prepared matcheck for G-tube. LPN-B turn disconnected the tusyringe into the G-tube. LPN-B turn disconnected the tusyringe into the G-tube distilled water into sent resistance. LPI placement by aspirate entered R40's room LPN-B with flushing check for G-tube plauscultation. LPN-E syringe with a narround G-tube and administ check for G-tube plauscultation prior to During interview on stated she had not prior to water flush per policy and care During interview on stated the G-tube in placement by aspirated.	change the bottle of Jevity tube. LPN-A took a 60 cc to a graduate container of ccs of tab water, opened and cleaned port with alcohol I the tip of the syringe into the empted to flush tube with 60 net resistance. LPN-A did not acement by aspiration or o starting the Jevity infusion. 10/31/16, at 2:25 p.m. LPN-A intube and did not check for orior to flush or starting on 11/01/16, at 7:37 p.m. redication and placed in or administer through R40's red off feeding pump, ribing, and placed the 60 ccs red off feeding pump, ribing, and placed the 60 ccs red off feeding pump, ribing, and placed the 60 ccs red off feeding pump, ribing, and placed to 60 ccs red off feeding pump, ribing, and placed to 60 ccs red off feeding pump, ribing, and placed to 60 ccs red off feeding pump, ribing, and placed to 60 ccs red off feeding pump, ribing, and placed to 60 ccs red off feeding pump, ribing, and placed the 60 ccs red off feeding pump, ribing, and placed the for G-tube ation or auscultation. RN-A or and attempted to assist ribing the G-tube ribing the feeding pump ribing the feeding p	F 2	82			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245399	B. WING		11/03/2016
	PROVIDER OR SUPPLIER	3	1	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST ITTLE FALLS, MN 56345	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 282 F 309 SS=D	new feeding. RN-A 6/16/16, was not fol During interview on DON stated R40's dexpected placement every time prior to reflushes, and starting 483.25 PROVIDE CHIGHEST WELL BUTTONICHEST WEIGHT WELL BUTTONICHEST WEIGHT WE	stated R40's care plan dated llowed. 11/03/16, at 11:00 a.m. the care plan was correct and she at of the G-tube be checked medication administration, go the tube feeding. CARE/SERVICES FOR	F 282		12/13/16
	by: Based on observat review, the facility for positive airway pres machine as directed the use of the CPAI utilized a CPAP. In re-assess and devel positioning for 1 of observed to lean in Findings include: R40's undated Face indicated R40's diag respiratory failure wanount of oxygen re	ion, interview, and document ailed to apply a continuous soure (CPAP) breathing d or document the refusal of P for 1 of 1 resident (R40) who addition, the facility failed to elop interventions related to 1 residents (R23) who was the wheelchair. Sheet printed on 11/03/16, gnoses included chronic with hypoxia (deficiency in the eaching the body's tissues), as pneumothorax, chronic		LFHS ensures each resident receive care and services to attain or maintain their highest practicable physical, mand psychosocial well-being. R#40- New physician orders were obtained for CPAP use. R#23- was re-assessed by occupating therapy and a new wheelchair was provided. All residents who utilize a CPAP and utilize wheelchairs have the potential affected by a deficient practice in this area.	ain ental onal I who Il to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG		E SURVEY PLETED	
		245399	B. WING _		11/0	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	obstructive pulmor condition-COPD) uapnea (a disorder more pauses in browhile sleeping). R40's General Nurserves as the care 10/19/16, indicated sleeping 8-9 hours R40's quarterly Min 10/24/16, indicated impairment, utilizer received extensive toileting, and need transfers using a had at risk for shortnes directed staff to elemonitor for SOB, anasal cannula. Care CPAP use. R40's physician or R40 was to have Ca day (day, evening bed. R40's physician nor R40 was to have Ca day (day, evening bed. R40's physician nor R40's wife was conevent R40 had on to continue with sa R40's electronic Tre (ETAR) dated Octoapply CPAP anytim	nary disease (lung inspecified, obstructive sleep where a person has one or eathing or shallow breathing se's Observation Note, which area assessment (CAA) dated a R40 was assessed as a night and 2-3 naps daily. Inimum Data Set (MDS) dated a R40 had severe cognitive doxygen (O2) therapy, assistance with bed mobility, ed total assistance with oyer lift. Ited 3/06/16, identified R40 was sof breath (SOB), and evate head of bed (HOB), and maintain O2 at 3-4 liters per re plan lacked direction for ders dated 10/04/16, indicated CPAP machine applied 3 times g, night) and anytime lying in the dated 10/24/16, indicated incerned about the hypoxic 10/23/16. Physician order was	F 30	All residents who utilize a way be assessed for proper porrefer to therapy as needed. Nursing staff were re-educe of CPAP and documentation CPAP. All Nursing staff were-educated on wheelchair and the need to report to the Manager if repositioning is. DON or designee will condesservational audits for whositioning. A minimum of week for 2 weeks, then 2 aweeks, then once weekly for then monthly thereafter. DON or designee will condesservational audits for CF minimum of 3 audits per weeks, then 2 audits/week once weekly for 2 weeks a monthly thereafter. Audit results will be brough Committee for review and recommendation. Completion date for F 309	ated on the use on of refusals of ere also positioning, ne Nurse unsuccessful. Juct random neelchair audits/week x2 or 2 weeks and luct random PAP use. A neek for 2 x2 weeks, then nd then at to the QAPI further	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		(X3) DATE SURVEY COMPLETED		
		245399	B. WING			11/0	03/2016
	PROVIDER OR SUPPLIER	3		12	REET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST ITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	10/31/16, did not in refused the CPAP to During interview on member (F)-A state should be on when At that time, R40 w per nasal cannula a on R40's night standon R40's night standon R40's night standon R40's night standon R40's nom and had standon Licensed properties and asked him if he did not acknowledge the CPAP During observation was in bed sleeping cannula on and CP During observation was in bed sleeping cannula on and CP During observation was in bed sleeping cannula on and CP	removed. s from 10/01/16, through dicate if or whether R40 had reatment. 10/31/16, at 1:37 p.m. family ed R40's CPAP machine he was sleeping or napping. as observed sleeping with O2 at 3 liters on, and CPAP sitting d. on 10/31/16, at 2:25 p.m. R40 d, and breathing through his at 3 liters per nasal cannula, CPAP was sitting on night actical nurse (LPN)-A was in d a difficult time arousing R40 e was sleeping at night. LPN-A te that R49 was not utilizing on 11/01/16, at 6:50 p.m. R40 g with HOB elevated, O2 nasal AP on nightstand.	F3	09			
		on 11/02/16, at 8:55 a.m. R40 g with HOB elevated, O2 nasal					

	OF CORRECTION I DENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3)	(X3) DATE SURVEY COMPLETED	
		245399	B. WING			11/03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		STREET ADDRESS, CITY, STATE, ZIP CO 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 309	registered nurse (R CPAP since admiss CPAP machine any the night, and at his documentation on t CPAP was applied, stated R40 refused would be charted in RN-A stated she wo on R40's care plan. During interview on licensed practical n would wear the CP after each nebulize saturations are belouiked to wear the CI LPN-A stated at that the ETAR was com did not reflect if the or removed. Review saturation rates we	11/02/16, at 9:49 a.m. IN)-A stated R40 had his sion on 2/06/16, and used the time he was sleeping, during a request. RN-A stated he ETAR does not reflect if the refused, or removed. RN-A CPAP at times, and refusals a the nursing progress notes. Duld expect to see the CPAP 11/02/16, at 10:13 a.m. urse (LPN)-A stated R40 AP when he was feeling SOB, or treatment, and if O2 DAP when he was napping. At time the documentation on pleted for the whole shift and CPAP was applied, refused, of the ETAR indicated O2 re normal at 90 or above. 11/03/16, at 11:00 a.m. the EDON) stated R40's CPAP is directed. The DON stated	F 3	309		
	R23 had moderate	S dated 10/5/16, indicated cognitive impairment, used a eded extensive assistance				
		on 11/1/16, at 12:46 p.m. R23 and leaning to the right in her ir.				

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245399	B. WING		1.	1/03/2016	
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	was seated in her voutside her room. We the right side of her shoulder pressed up minutes, her head it she appeared to be assisted into the dia attempt to reposition. During dining obserp.m. to 6:12 p.m. Rover and leaning to R23's head was hat touched the armress attempts were mad supper, however, nouter reposition R23. During observation was seated in a difference of the diameter of the nurse's station. Continued to be hur forward with her her no longer leaning to was assisted into the reposition R23 were R23's care plan data assistance with whe plan did not contain positioning nor did intervene. During interview on stated R23 had recomorning but was not seen as the side of the recomorning but was not stated R23 had recomorning but was not seen as the side of the recomorning but was not seen as the recommendation of the recommendat	on 11/1/16, at 4:59 p.m. R23 wheelchair in the hallway right While seated, R23 leaned to r wheelchair with her right ap against arm rest. After a few fell forward and to the right as asleep. At 5:32 p.m. R23 was ning room. Staff did not on R23 prior to dinner. Tryation on 11/1/16, from 5:38 t23 was observed hunched of the right in her wheelchair. Inging down so far it almost at of the wheelchair. Staff the to encourage R23 to eat her to attempts were made to on 11/2/16, at 7:18 a.m. R23 ferent standard wheelchair by In this wheelchair, R23 neched over and leaning the dining room. No attempts to	F3	09			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245399	B. WING		11	/03/2016
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COI 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	her bed or recliner. standard wheelchaifor positioning. During interview on occupational therapyosition in the wheelchair seemed armrests were a litt resident is more "sl not able to hold the a referral to therapy OT-A was unaware assessed by therapy During interview on assistant (NA)-G stafter meals and whistated she tried to recliner or by placin NA-G further stated [staff] could do." During interview on stated she would as R23 was leaning in she would roll up a R23's wheelchair a should have interve positioning. During interview 11 therapist (PT)-A states assess wheelchair they were appropristated R23's current stated R23's c	should offer repositioning to LPN-E was unsure if R23's ir had been sized or assessed 11/2/16, at 9:07 a.m. bist (OT)-A observed R23's elchair and stated R23 sat often. OT-A stated the current I "a bit big" for R23 and the le high. OT-A stated when a oppy" in the wheelchair or is mselves up, staff should make v to assess the wheelchair. if R23's wheelchair had been	F 3	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245399	B. WING _		11/	03/2016	
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLÉTION		
F 309	During interview on was not aware of R wheelchair, further R23's wheelchair upappropriate, and did RN-A stated R23 to posture and expect she was uncomfort further stated the enursing assistants to leaning more in the stated the positioning R23's care plan becommon sense." During interview on stated wheelchairs and if residents well positioning issues if therapy to assess to were expected to rethem as needed. The would expect position the care plans. A facility policy entity Equipment, undated provide equipment highest most practicy policy also directed therapy for position recommendations.	her stated it was not routine ss all wheelchairs. 11/3/16, at 1:38 p.m. RN-A	F 30			12/13/16	
SS=D	IMPROVE/MAINTA		1 01			12,10,10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245399	B. WING			11/03/2016	
	PROVIDER OR SUPPLIER FALLS CARE CENTE	R		12	REET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST ITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 311	A resident is given services to maintai specified in paragra. This REQUIREME by: Based on observareview, the facility for 1 of 1 residents with a restorative period of 1 residents on 1 residents of 1 re	the appropriate treatment and n or improve his or her abilities aph (a)(1) of this section. NT is not met as evidenced tion, interview, and document ailed to reassess and nent an ambulation program (R23) reviewed for ambulation rogram. Inimum Data Set (MDS) dated R23 had moderate cognitive edded extensive assistance of both in her room and outside. Red physician orders, dated 23 was to walk to meals three and facility nursing assistant fed R23 was on a restorative RNP) and directed staff to walk plan dated 1/31/16, directed	F3	3311	LFHS ensures each resident is give appropriate treatment and services maintain or improve his or her ability. R#23 was referred to Physical ther 11-2-16 for ambulation assessment A restorative ambulation program with developed and entered on the care and NAR group sheet. All residents on restorative ambulation program with the potential to be affected by deficient practice in this area. All residents with ambulation program will be reviewed to ensure that the is appropriate. All NAR and Nursing staff were edition R23 is ambulation program and documentation of restorative ambulation programs.	to ties. apy on t. vas plan tion r a ams service	
	ambulation. The Facility Treatm 9/16, and 10/16, co to meals 3 times per second secon	nent Sheet Records, for 8/16, ontained the order to walk R23 er day. The Treatment Sheets y nursing staff to show curred.			Random observational audits will be completed to ensure that ambulation programs are being implemented. designee will conduct random audit minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 week once weekly for 2 weeks and montathereafter.	on DON or ts. A 2 ks, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245399	B. WING _		11/	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		STREET ADDRESS, CITY, STATE, ZIP 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 311	Detail Report, from total walking/restora received. It identifies restorative ambulated days in July, twenty days in September, identified R23 had a mbulation yet in North During observation was seated in her word (NA)-D was observed R23's wheelchair at the dining room for was made to walk word During interview on stated the nursing a R23 in her wheelch R23 did not walk as stated the staff did because R23 was "kind of crazy." During observation was being pushed in nurse's station into During interview on practical nurse (LPI restorative program due to knee pain. Les nursing assistants with R23, however, throughout the day, was documented of the staff of the s	entitled, Walking Therapy 2/1/16 to 7/1/17, showed the ative care services R23 had d R23 had received ion one day in June, fourteen two days in August, fourteen and seven days in October. It not received restorative ovember. on 11/1/16, at 5:32 p.m. R23 wheelchair. Nursing assistant ed to put foot pedals onto nd proceeded to push R23 to supper. No attempt or offer	F 3	Audit results will be brough committee for review and frecommendation. Completion date for F 311	further	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		` '	COMPLETED			
		245399	B. WING _	·····	1	1/03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 311	During observation was in her room se had been transferre wheelchair by NA-Cobserved to be pushous During interview on stated R23 had refurther stated it was that afternoon. NA-walk to meals and restorative ambulated During interview on physical therapist (therapy when she whad been discharge recommendations program. PT-A stated R25 ft (feet) to 50 ft at the the thing of the dining room. Walk all the way frood dining room, but the walk her once R23 During observation ambulated R23 in the R23 did not have a ambulation. However of ambulating once	on 11/2/16, at 11:52 p.m. R23 rated in her wheelchair. R23 red from the bed into the G and NA-I. R23 was again shed in her wheelchair to lunch. In 11/2/16, at 12:02 p.m. NA-G used to walk to lunch and is hard for R23 to even stand of stated R23 does not ever was not aware R23 was on a tion program. In 11/2/16, at 12:07 p.m. PT)-A stated R23 had received was admitted to the facility and red with therapy for a restorative ambulation red R23's goal was to ambulate at a time. PT-A further stated residents quarterly which cline in mobility, however, was puarterly screenings or therapy	F3:			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245399	B. WING		11,	/03/2016
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODI 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 311	was longer. During interview on registered nurse (Rassistants were resand thought R23's in program was being ambulate to the bat further stated LPN's monitoring the comprogram. RN-A though documentation was walking and staffine RN-A stated R23 ratespecially with encounter distance between room was "under retreassessed. During interview on stated restorative proconsistently as orderedoing the ambulation procumentation error A facility policy entite Program Policy, revease the responsibil Coordinator (a registerestorative goals for aspects of the restoration and the restorative goals for aspects of the restoration and the restorative goals for aspects of the restoration and the restorative goals for aspects of the restorative goals for aspects of the restorative goals for a spects	11/3/16, at 1:38 p.m. 11/3/16, at 1:38 p.m. 1N)-A stated the nursing ponsible for walking with R23 restorative ambulation done as she often saw R23 chroom and in her room. RN-As were responsible for pletion of the ambulation ught the ambulation on trepresentative of R23's peeded education on charting. The programs were not getting done are lightly but had not been fully 11/3/16, at 3:55 p.m. RN-C rograms were not getting done are and were currently performed and were currently attended the inconsistency in	F3	311		

AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	245399	B. WING _		11/	03/2016	
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
recommendations) w provided. F 314 SS=D REVENT/HEAL PRI Based on the compreresident, the facility m who enters the facility does not develop preindividual's clinical conthey were unavoidable pressure sores receives ervices to promote here. This REQUIREMENT by: Based on observation review, the facility fails services to provide set healing of pressure under the form of 3 residents (Fulcers who was not on relief to the heel, and infection control technical wound cares. Findings include: R2's Face Sheet identifacility on 9/30/16, with anemia, weakness, and disorder.	ty document entitled, Program (containing therapy ras requested but not NT/SVCS TO ESSURE SORES The ensive assessment of a must ensure that a resident y without pressure sores ressure sores unless the prodition demonstrates that le; and a resident having wes necessary treatment and mealing, prevent infection and mealing, prevent infection and mealing, prevent infection and previces to promote the field to provide necessary for ervices to promote the field to provide necessary for pressure field to provide to have pressure field to have pressur	F 31		s a eceives the es to ew ulcers p sheets to reflect ulcer and es for tre ulcers e in this	12/13/16	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245399	B. WING		11/03/2016	
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	10/7/16, identified Fulcers, had one State unstageable pressureducing device for was on a turning and The 14-day schedul 10/12/16, identified ulcers, had one state unstageable pressult also identified prechair and bed, and repositioning programs. During observation was lying in bed on were noted to be difloated (lifted off material buttock and gloves, removed the buttock, and donne performing hand hyindicated being una and identified the word unstageable. RN-C sea Cleans (wound gloves, RN-C place wound. At this time incontinent pad fastup. RN-C then procovered R2's torso, from the left heel. as unstageable. RI	R2 was at risk of pressure age 2 pressure ulcer and one ure ulcer, had a pressure the chair and bed, and R2 and repositioning program. Ied assessment MDS dated R2 was at risk of pressure ge 2 pressure ulcer and one ure ulcer, and none worsening. Essure reducing device for the R2 was on a turning and	F 314	will be reassessed and intervention be developed based upon the assessment. NAR staff were re-educated on R# care plan, including the turning and repositioning program pertaining to protection (and the need to report to nurse if the resident is refusing heap rotection). Nursing staff were re-educated on infection control techniques during dressing changes. DON or designee will conduct rand observational audits of residents wheel ulcer or at high risk of heel breakdown identified to require heep rotection. A minimum of 3 audits week for 2 weeks, then 2 audits/weweeks, then once weekly for 2 weeks, then monthly thereafter. DON or designee will conduct rand observational audits of dressing changes to ensure proper infection control technique, 2Xweek x 2, weekly X2, monthly thereafter. Audit results will be brought to the committee for review and further recommendation. Completion date for F 314 is 12/13	2 s heel to the el lom ith a el per eek x 2 eks, lom anges , and QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245399	B. WING	B. WING		11/03/2016	
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		STREET ADDRESS, CITY, STATE 1200 FIRST AVENUE NORTHE LITTLE FALLS, MN 56345	EAST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BI O THE APPROPRIA		
F 314	sprayed on the wou without performing dressing was place were then removed a pillow beneath R2 the bed, then lower remote. At this time and washed her had On 11/3/16, at 8:54 began. R2 was obin the dining room, was observed in opback half of the slip heel, resting directly half off of the foot mext to resident, wit reposition R2's left assisted to the actin observed unchanger remained in the act director (AD) assist offer to adjust the leassisted R2 out of the room. At 11:18 a.m bathroom, and NA-Continuous observed hours and 24 minut wheelchair, with he resting on the foot in not offer to reposition independent of the proposition independent of the proports dated 9/30/	and, and gloves were changed, hand hygiene. A clean d on the wound. The gloves I, and RN-C assisted to place It's legs to float the heels offed the bed with the attached I, RN-C went to the bathroom Inds. a.m. continuous observation served sitting in her wheelchair eating breakfast. R2's left foot bened back slipper, with the oper and foot, including the yon the foot rest, and the front lest. Therapy staff was sitting Ith no offer to assist to foot. At 9:56 a.m. R2 was wity room, with left foot ed. At 10:28 a.m. R2 ivity room for coffee. Activity ed R2 to the table, making no left foot. At 11:10 a.m. AD the activity room, and to her in R2 asked to use the F entered to assist. Action ended at this time. For 2 ites, R2 remained in her in foot observed with the heel rest. During this time, staff did on and R2 was not observed endently.	F3	314			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245399	B. WING			11/03/2016	
_	PROVIDER OR SUPPLIER FALLS CARE CENTE	3		12	REET ADDRESS, CITY, STATE, ZIP CODE 00 FIRST AVENUE NORTHEAST TTLE FALLS, MN 56345		
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F 314	reposition side to s 10/4/16 1.5 x 1.4 No change to appe 10/11/16 1.0 x 1.0 100% epithelial tiss 10/18/16 0.8 x 0.7 cm open wound edges even pressure reducing of	sue age on ting mattress ting cushion for wheelchair ide in bed and in recliner arance of wound. sue and unremarkable or relieving device(s) in place e bed surface and chair sue e drainage	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION UNG		(X3) DATE SURVEY COMPLETED		
		245399	B. WING			11/0	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		STREET ADDRESS, CITY, STATE, ZIP 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	Г		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD IE APPROPI	BE	(X5) COMPLETION DATE
F 314	have had a change is determined that chair was changed washed and returni Family felt resident replaced cushion with dody to a pressure continues to be replaced cushion with dody to a pressure continues to be replaced cushion with dody to a pressure continues to be replaced. Dressing Deterioration noted stage. Dressing Deterioration noted stage. Slough and/ Facility electronic Trunch Record (ETAR) Residentified an order of Foam dressing Q30 [as needed] to upper day every 3 days during the same plex. Notify RN initialed this as bein ordered. The order to coccyx/low back Document Dressing	inage ue ed pink and observed to be	F3	114			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245399	B. WING		11/	03/2016	
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 314	daily. document ch RN of any s/s [signs	ge 32 structions: Meplex change paracteristics, drainage. Notify s and symptoms] of infection."	F3	314			
	dated 9/30/16 throu	ort For Selected Conditions igh 10/25/16, identified the a pressure ulcer on the left					
	bed, noted as dated turn and repositioni sheep skin booties float heels when lay	e is macerated ar					
	10/4/16 2.7 x 4.0 (only measurement note)	s available from RN-C - no					
	10/11/16 2.6 x 4.0 (only measurement note)	s available from RN-C - no					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPLETED			
	245399	B. WING		11,	/03/2016
	3		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	,	
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	ILD BE	(X5) COMPLETION DATE
10/19/16 2.6 x 4.0 (only measurement note) 10/19/16 wound base not vis 100% eschar tissue 2.6 x 4.0 10/21/16 drainage thin, scan 10/25/16 wound base not vis slough and/or esch 2.6 x 4.0 no drainage appare	is available from RN-C - no ible t, brownish red ible ar covered	F 3	14		
note) Facility ETAR Report an order dated 10/6 Exudate: Foam dresheel 1 time per day Instructions: Clean notify RN if change this as being completed date were to provide extended to the continued for Nove being completed date were to provide extended to the continued for Nove being completed date were to provide extended to the continued for Nove being completed date were to provide extended to the continued for Nove being completed date.	ort for October, 2016, identified 6/16, "Moderate/Heavy essing QD [every day] to left during Evening, Special wound and dress. Please in wound site." Staff initialed leted daily. The same order mber 2016, and was signed as aily. dd 10/31/16, identified staff ensive assistance as follows:				
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa 10/19/16 2.6 x 4.0 (only measurement note) 10/21/16 drainage thin, scan 10/25/16 wound base not vis 100% eschar tissue 2.6 x 4.0 10/21/16 drainage thin, scan 10/25/16 wound base not vis slough and/or esch 2.6 x 4.0 no drainage appare covered with black 11/1/16 2.4 x 3.7 (only measurement note) Facility ETAR Repo an order dated 10/6 Exudate: Foam dre heel 1 time per day Instructions: Clean notify RN if change this as being comple continued for Novel being completed da R2's care plan date were to provide ext	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 10/19/16 2.6 x 4.0 (only measurements available from RN-C - no note) 10/19/16 wound base not visible 100% eschar tissue 2.6 x 4.0 10/21/16 drainage thin, scant, brownish red 10/25/16 wound base not visible slough and/or eschar covered 2.6 x 4.0 no drainage apparent covered with black eschar 11/1/16 2.4 x 3.7 (only measurements available from RN-C - no	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 10/19/16 2.6 x 4.0 (only measurements available from RN-C - no note) 10/21/16 drainage thin, scant, brownish red 10/25/16 wound base not visible slough and/or eschar covered 2.6 x 4.0 10/21/16 10/25/16 wound base not visible slough and/or eschar covered 2.6 x 4.0 10/19/16 2.6 x 4.0 10/21/16 Take of the provide of the provided an order dated 10/6/16, "Moderate/Heavy Exudate: Foam dressing QD [every day] to left heel 1 time per day during Evening, Special Instructions: Clean wound and dress. Please notify RN if change in wound site." Staff initialed this as being completed daily. The same order continued for November 2016, and was signed as being completed daily. R2's care plan dated 10/31/16, identified staff were to provide extensive assistance as follows:	PROVIDER OR SUPPLIER 245399 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 10/19/16 2.6 x 4.0 (only measurements available from RN-C - no note) 10/21/16 drainage thin, scant, brownish red 10/25/16 wound base not visible slough and/or eschar covered 2.6 x 4.0 (only measurements available from RN-C - no note) Facility ETAR Report for October, 2016, identified an order dated 10/6/16, "Moderate/Heavy Exudate: Foam dressing OD [every day] to left heel 1 time per day during Evening, Special Instructions: Clean wound and dress. Please notify RN if change in wound and spene provide extensive assistance as follows: R2 scare plan dated 10/31/16, identified staff were to provide extensive assistance as follows:	PROVIDER OR SUPPLIER 245399 RALLS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 33 10/19/16 2.6 x 4.0 (only measurements available from RN-C - no note) 10/25/16 wound base not visible 100% eschar tissue 2.6 x 4.0 10/21/16 drainage thin, scant, brownish red 10/25/16 wound base not visible slough and/or eschar covered 2.6 x 4.0 10 no drainage apparent covered with black eschar 11/1/16 2.4 x 3.7 (only measurements available from RN-C - no note) Facility ETAR Report for October, 2016, identified an order dated 10/6/16, "Moderate/Heavy Exudate: Foam dressing QD (every day) to left heel 1 time per day during Evening, Special Instructions: Clean wound and dress. Please notify RN if change in wound site." Staff initialed this as being completed daily. The same order continued for November 2016, and was signed as being completed daily. R2's care plan dated 10/3/1/6, identified staff were to provide extensive assistance as follows:

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		245399	B. WING			11/0	03/2016
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP OF 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	CODE		, , , , , , , , , , , , , , , , , , , ,
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F 314	- Assistance of two - R2 had a pressur with an intervention and reposition ever - Monitor for positio - Cushion to wheel Nursing assistant obe repositioned evidentified skin issue mattress. Facility Admissions dated 9/30/16, and identified on 9/30/1 medial Buttock: 1. ulcer, irregular shaminimal drainage. dressing, placed 30 coccyx that is nonbapplied. It also idenecrotic area. Duc 2.7 cm x 4 cm ulce edges of wound be eschar. Peeled Aquibserve site and response of the proposition of	ike resident to the toilet. Is staff for ambulation It e ulcer to coccyx / low back, In of an air mattress and to turn It y two to three hours. It also It als	F3	314			
	documentation date failed to identify a p	ional and physical therapy ed 9/30/06 through 11/3/16, pressure ulcer on the mid right st for evaluation of an					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	•		
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F 314	registered nurse (Runstageable pressuloss in which the baslough) to the left hipressure ulcer (part presenting as a shapink wound bed, wibuttock. During interview on assistant (NA)-A de issues with R2. White R2 in the morning, from beneath her knield replaced. NA-A verdirectly on the mattifloated. During interview on stated staff would be the dressing on the contaminated, or lot to notify RN-A with if there were a chardenied being aware and denied being aware and denied being in pressure ulcer prior 11/1/16. On admission ordered every three changed to daily. Echanged more frequistated R2 has a number in bed. RN-C floated that morning wound care, and was solved.	-	F3	314				

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	PROVIDER OR SUPPLIER FALLS CARE CENTER	1		120	REET ADDRESS, CITY, STATE, ZIP CODE 00 FIRST AVENUE NORTHEAST TTLE FALLS, MN 56345		
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F 314	report any changes the RNs. During interview on member (F)-C state cushion were lost, a located, but the cus number of days. The of days later. F-C stort wo to three day about three to five on 10/16 and found remained missing, black and yellow cut during the care con that the cushion was complained that he 10/24/16, RN-A procushion. On 11/1/1 currently being used. During interview on stated R2 has a drebuttock. It was bein and was changed to would look if R2 haverify it with a name the cushion should clarifying with an RI the chair or cushior stated R2 is to be to two to three hours. black slippers that stated results and stated results are reported to the results and the cushion should clarifying with an RI the chair or cushior stated R2 is to be to the control of the results and results are reported to the results and results are reported to the results	or non-compliance to one of 11/2/16, at 10:25 a.m. family ed initially the chair and the and then the chair was shion remained missing for a ne pad was located a number stated the chair was missing s, and the pad was missing s, and the pad was missing on 10/17. The cushion and R2 was provided a vinyl shion to use. On 10/19/16, ference, family complained s missing and R2 had r bottom was hurting. On vided R2 with a different 6, RN-C provided the cushion d. 11/3/16, at 1:31 p.m. NA-F essing on her upper right ng changed every three days, of daily. NA-F stated staff d a cushion, but would not ever anything. Staff are aware not be replaced without N. NA-F was not aware that a had been missing. She curned and repositioned every NA-F stated R2 has her own she wears. There is no back is not aware of any special	F3	14			

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F 314	During interview on stated R2 is current R2 was referred for believed therapy althe wheelchair size wheelchair at any padmission resident first 24 hours, and applied as needed, RN-A stated she would there were a chang reported to the RN. that there was a depreviously a Stage RN-A added, "[R2] stated she would expreviously a Stage RN-A added, "[R2] stated she would expreviously a Stage RN-A added, "[R2] stated she would expreviously a Stage RN-A added, "[R2] stated she would expreviously a Stage RN-C and verified she has concerns with this. During interview on verified the wound a Stage 2 to unstage was increased from The nurse practition to continue current aware of a change discovered the charge discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the discovered the charge incorrect cushion be knowledge of the charge incorrect cushion be knowle	11/3/16, at 2:29 p.m. RN-A tly in therapy, but is not sure if a proper cushion, but ways looked at residents for. The cushion that is in the oint should be used. After s skin is checked within the a cushion and air mattress is which staff are always to use. Fould expect that staff notice if e in the cushion and this be RN-A was unwilling to state cline in the wound if it was 2, and currently unstageable. The really likes the slippers." RN-A expect staff report any change in floating the heels, is not been informed of any 11/3/16, at 1:38 p.m. RN-C to the upper buttock went from leable. The dressing change in every three days to daily. The really likes the slippers or every three days to daily. The dressing change in every three days to daily. The dressing change in the wound. When she had orders, and verified being to the wound. When she had one on 11/1/16, during wound and the correct cushion on the stated she believed the root ge in the wound was the ening used. She denied ifferent cushion being used,	F 3	14				
	her. RN-C stated we she found a black a adequate for pression this with a flatter cu	staff notice this, they inform when the cushion was missing, and yellow cushion that was ure ulcers. Family replaced shion from home, since they k and yellow cushion,						

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F 314	indicating it made F not inform the facili cushion. R2 used to week. When she be the cushion to what stated the change if avoidable, had the RN-C also stated so assess for a proper say for sure if this he unable to find any costated assessment need to change the schedule from ever change in the wour stated no assessment determine if this so R2 was in bed or cl RN-C stated R2's he	age 38 R2 sweat. However, they did ty they had changed the the thinner cushion for one became aware, RN-C replaced to R2 is currently using. RN-C in the pressure ulcer was cushion not been changed. The assumed therapy would recushion, but was not able to had been done for R2, and was documentation. RN-C also determined there was no exturning and repositioning by two to three hours after the had. However, RN-C also ent had been completed to hedule was still sufficient while hair. Related to the heel, neel should not be resting rest, and staff education was		314				
	stated RN-C is wou recommendations, required assessme was more appropria interventions than to certified. DON wou worsened going frosince she had not so DON stated NAs working in the cush trained in this. The cushion, but that is p.m. DON stated the cushion the family prerified there is no	a 11/3/16, at 2:10 p.m. DON and certified, and with her there is not a change that ant. DON also indicated RN-Cate to recommend herapy as she is wound ald not acknowledge ulcer had an a Stage 2 to unstageable, seen it when R2 was admitted. Ould report if they noted a ion, but added they are not by would know there is a it. Further interview at 2:57 here was a change due to the colaced in the chair, and process in place to ensure the cushion was in place for						

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F 318 SS=D	11/1/15, indicated s prevent, treat, and ulcer(s). It also insists skin ulcers to the w circulation by change review all current in remain appropriate 483.25(e)(2) INCRE IN RANGE OF MOBES on the compresident, the facility with a limited range appropriate treatments.	Skin Ulcer Protocol, updated ervices will be provided to monitor progress of all healing tructed staff to report all open ound nurse, improve ging position frequently, and terventions to ensure they EASE/PREVENT DECREASE TION Trehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further		314			12/13/16
	by: Based on observat review, the facility for range of motion (RG recommended for 1 on a restorative RC Findings Include: R23's quarterly Min 10/5/16, identified F impairment and no both upper and low	of 1 residents (R23) reviewed M program. imum Data Set (MDS) dated R23 had moderate cognitive functional limitation in ROM in			R# 23 was referred to Occupational Therapy for ROM program on 11-2-restorative range of motion program developed and entered on the care and NAR sheet. Restorative and NAR staff were educated in R#24 s ROM program. All residents with restorative ROM programs have the potential to be impacted by a deficient practice as relates to range of motion services.	16. An was plan ucated	

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	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		12	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST ITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	Module, dated 1/12 lower extremity flex initial ROM assess A General Nurse's contained a Restora R23 participated in ROM six times wee Osteoporosis and participated in ROM service R23 as being on a receiving ROM. During observation nursing assistant (Nevening cares before from her wheelchai were performed being buring observation was seated in her was tation. R23's morn performed. No ROM During interview on practical nurse (LPI ROM services from morning with morning and received Fouring interview on During interview	716, indicated R23 had a right ion limitation noted during the ment. Observation, dated 10/5/16, ative Assessment indicating upper and lower extremity kly, related to diagnosis of previous Left Hip Fracture. Indicated R23 was on a restorative NP) but did not list ROM ed 1/31/16, indicated R23 with mobility. It did not identify restorative program or on 11/1/16, at 6:47 p.m. IA)-E assisted R23 to perform the assisting to transfer R23 resisting to transfer R23 resisted No ROM exercises fore R23 went to bed. on 11/2/16, at 7:18 a.m. R23 wheelchair by the nurse's ing cares had been of M was observed. 11/2/16, at 7:44 a.m. licensed N)-E stated R23 received the nursing assistants in the ng cares. LPN-E was unsure if	F3	18	All residents with ROM programs verviewed to ensure that the service appropriate. DON/designee will conduct random observational audits to ensure that programs are being completed and documented. A minimum of 2 audit week for 2 weeks, then 2 x week x weeks, then once weekly for 2 weemonthly thereafter. Audit results will be brought to the committee for review and further recommendation. Completion date for F 318 is 12/13	es are ROM d ts per 2 eks and	

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	COMPLETED	
		245399	B. WING			11/	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 318	therapy room and a groups after breakfurther stated R23 h morning. During interview on physical therapist (I therapy when she whad been discharge recommendation for ROM. PT-A was unwhich ROM was reto find the original r further stated no R0 room. During observation performed ROM with wheelchair. PT-A st functional decline in During interview on stated the facility had who were trained to who completed RO assistants were not "nobody, I don't thin During interview on stated the nursing a completing ROM if not available, howe not being complete further stated the fa afternoons for restor ROM. Now the rest get ROM in by setting the stated the stated the facility had been declared to the facility had been declared to the stated the fa	attended restorative therapy ast or in the afternoon. NA-G and not received ROM yet that 11/2/16, at 12:07 p.m. PT)-A stated R23 had received as admitted to the facility and ed with therapy rupper and lower extremity sure of the frequency with commended and was unable ecommendations. PT-A DM was done in the therapy on 11/3/16, at 8:03 a.m. PT-A th R23 while sitting in her ated R23 did not have a ROM. 11/3/16, at 7:46 a.m. NA-H ad two restorative assistants operform ROM. When asked M services if the restorative in the facility, NA-H replied,	F3	318			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245399	B. WING _	·····	11	/03/2016	
	PROVIDER OR SUPPLIER FALLS CARE CENTE	3		STREET ADDRESS, CITY, STATE, ZIP CO 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 318	stated the restorating ROM seven days a staffing was, she wassistant than in the stated when working would be pulled on cares. During interview on registered nurse (Freceive ROM once stated the restorating for completing ROM the facility had strue always have restorating assistant realso responsible for ROM nursing assistant. If had attempted to othe residents to state acknowledged not were equivalent to the residents to state acknowledged not getting done constated the daily resulted from the perform nursing carbon stated the facility has assistants. If restorate facility would attempted to the facility would attempted the facility attempted the facility would attempted the facility would attempted the facility would attempted the facility would attempted the facility attempted the facility would attempted the facility attempted th	we assistants tried to complete week. NA-E stated the way orked more as a nursing e restorative role. NA-E further ig in the restorative role she to the floor to do nursing 11/3/16, at 1:38 p.m. 11/3/16, at 3:55 p.m. 11/3/16, at 3:55 p.m. RN-C torative ROM programs were insistently as ordered due to her stated the floor to	F 31	8			

AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245399	B. WING	i		11/0	03/2016
	PROVIDER OR SUPPLIER	3		1	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	2/1/16 to 11/3/16, sl	ge 43 entitled, Therapy Audit, from howed the ROM services R23 ntified R23 had received ROM	F 3	318			
	2 days in February, days in July, fifteen September, and sev indicated R23 had r	six days in June, twenty one days in August, twelve days in ven days in October. It not received any ROM in y and had not received ROM					
	11/8/15, directed reto be conducted da	led Range of Motion, reviewed storative ROM programs were ily, on a one to one basis, and re to be performed in the					
F 322 SS=D	Restorative Nursing recommendations) provided.	ility document entitled, g Program (containing therapy was requested but not REATMENT/SERVICES - G SKILLS	F3	322			12/13/16
		rehensive assessment of a must ensure that					
	alone or with assistatube unless the resi	nas been able to eat enough ance is not fed by naso gastric ident's clinical condition use of a naso gastric tube was					
	gastrostomy tube re treatment and servi pneumonia, diarrhe	s fed by a naso-gastric or eceives the appropriate ces to prevent aspiration a, vomiting, dehydration, lities, and nasal-pharyngeal					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245399	B. WING		11/0	03/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 1200 FIRST AVENUE NORTHEAS LITTLE FALLS, MN 56345	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 322	skills.	age 44 ore, if possible, normal eating ENT is not met as evidenced	F3	22			
	by: Based on observareview, the facility the gastrostomy tu stomach for feeding an eternal feeding residents (R40) where Findings include: R40's physician or G-tube feeding Jewhour times 24 hour indicated he was to G-tube with 30 cub before and after material and the check placemer medications via the orders. During observation licensed practical inchange bottle of Jewhole LPN-A took a 60 control graduate contained the tab water, opened cleaned port with a tip of the syringe in attempted to flush met resistance. LF placement by aspired.	ation, interview, and document failed to check placement of the (G-tube, a tube to the ag) prior to the administration of and medication for 1 of 1 no had a G-tube. der dated 10/4/16, directed vity 1.2 at 65 milliliters (ml) per rs. R40's medication orders to receive his medications via bic centimeter (cc) flushes		LFHS ensures a resident receives the appropriate to services to prevent compropossible, to restore normal R#40- Nursing staff caring re-educated on the procerplacement of the G-tube. All residents with G-tubes potential to be affected by deficient in this area. All licensed staff were rechecking placement of a directed by the facility G-technology and the composervational audits of Gensure appropriate check of the tube. A minimum of the tube. A minimum of the tube weeks, then 2 weeks, then once weekly then monthly thereafter. Audit results will be broug committee for review and recommendation.	reatment and lications and if al eating skills. If or R#40 was see for checking thave the random and an analysis and the policy and the poli		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245399	B. WING		11	/03/2016	
	PROVIDER OR SUPPLIER FALLS CARE CENTE	3		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345			
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F 322	tip. LPN-A got a dif- narrow tip from R44 with 60 cc of water and flushed G-tube G-tube placement I LPN-A connected r G-tube port and sta- confirmed R40 had check for G-tube pl starting infusion of During observation prepared medication cup to administer the entered R40's room stethoscope around and donned gloves water into the medi- medication prior to off feeding pump, or placed the 60 cc's s LPN-B then poured syringe to flush via LPN-B was unable water after several LPN-B did not check aspiration or auscul walkie talkie and as coke to R40's room nurse (RN)-A ente assist LPN-B with f repositioning R40 at tubing. RN-A did not by aspiration or aus different 60 cc syrin able to flush G-tube LPN-B did not check aspiration or auscul assist LPN-B did not check aspiration or auscul assist control of the control control o	to use a syringe with a narrow ferent 60 cc syringe with a 0's closet, filled the syringe r, and opened the G-tube port to LPN-A did not check for by aspiration or auscultation. New tube feeding to R40's arted the feeding pump. LPN-A a G-tube and she did not accement prior to flush or Jevity. on 11/01/16, 7:37 p.m. LPN-B on and placed medication in a arrough R40's G-tube and n. LPN-B who had a did her neck, washed her hands, then poured 30 cc's of tap cation cup to dissolve the administration. LPN-B turned disconnected the tubing, and syringe into the G-tube port. If 60 cc's of distilled water into gravity and met resistance, to administer the flush with attempts to manipulate tubing. Sk for G-tube placement by ltation. LPN-B got on the sked the nurse to bring some into flush G-tube. Registered ared room and attempted to lushing G-tube by and massaging the G-tube placement scultation. LPN-B used a nege with a narrow tip and was a and administer medication. Sk for G-tube placement by and administer medication. Sk for G-tube placement by and administer medication.	F 322	Completion date for F 322 is 12	/13/16		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245399	B. WING		11/	03/2016	
	PROVIDER OR SUPPLIER	ł		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 322		ge 46 she had not checked G-tube to flush or administering	F3	22			
F 441 SS=E	medication. During interview on stated the G-tube n placement by aspira flushing, medicatior new feeding. RN-A policy dated 6/01/16 confirmed at that tirbeen checked for p meeting resistance. During interview on director of nursing (was correct and she G-tube be checked administration, flush feeding. The facility policy M through an Enteral nurse to check tube administering medic G-tube. The policy pinstructions on check 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and control to help prevent the confidence of disease and infection Control The facility must es Program under whice	11/01/16, 8:20 p.m. RN-A eeded to be checked for ation or auscultation prior to administration, and starting confirmed enteral feeding 6, was current. RN-A me R40 G-tube should have lacement especially when 11/03/16, at 11:00 a.m. DON) stated R40's care plane expected placement of the every time prior to medication nes, and starting the tube edication Administered Tube revised 7/8/16, directed eplacement prior to cations and feeding via a provided step-by-step cking the tube for placement. I CONTROL, PREVENT tablish and maintain an ogram designed to provide a omfortable environment and development and transmission ction.	F 4	41		12/13/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		SURVEY PLETED	
		245399	B. WING		11/0	03/2016
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	should be applied t (3) Maintains a rec- actions related to ir (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each d hand washing is inc professional practic (c) Linens Personnel must ha	rocedures, such as isolation, o an individual resident; and ord of incidents and corrective infections. ead of Infection tion Control Program esident needs isolation to of infection, the facility must in the prohibit employees with a ease or infected skin lesions with residents or their food, if transmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 44	1		
	by: Based on observa review the facility fa hygiene was impler observed for wound failed to ensure appractices were follow who was in contact Findings include:	NT is not met as evidenced tion, interview and document ailed to ensure proper hand mented for 1 of 1 resident (R2) d care. In addition, the facility propriate infection control based for 1 of 1 resident (R49) is isolation.		LFHS has established an Infecti Control Program designed to pro- safe, sanitary and comfortable environment and to help prevent development and transmission of and infection. R#2-Nursing staff providing woul for R#2 were re-educated on pro- hygiene (washing hands when chapters) with wound care.	the f disease and care per hand	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245399	B. WING			11/(03/2016
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				12	REET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST ITTLE FALLS, MN 56345		0,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	(RN)-C entered R2 changes to the premedial buttock and gloves, removed the buttock, and donner performing hand hy area with Sea Cleathe same gloves, Fon the wound. At tremoved, incontine pulled back up. RN clean gloves (withor R2's torso, and remeleft heel. The Sea wound, and gloves performing hand hy placed on the wour removed, and RN-C beneath R2's legs flowered the bed wittime, RN-C went to hands. During interview on stated she typically between each wou soiled gloves each hand hygiene was the entire process of the control of the contro	(DON) and registered nurse 's room to perform dressing soure ulcers on her right left heel. RN-C donned e old dressing from the ed clean gloves, without regiene. RN-C then sprayed the ans (wound cleanser). With RN-C placed the new dressing his time, the gloves were not pad fastened, and pants N-C then proceeded to don the washing hands), covered noved the dressing from the Cleans was sprayed on the were changed, without regiene. A clean dressing was not. The gloves were then C assisted to place a pillow to float the heels off the bed, the the attached remote. At this the bathroom and washed her a 11/2/16, at 9:24 a.m. RN-C performs hand hygiene and, but not after removing the time. RN-C also verified no performed until finished with during the observation. 11/3/16, at 2:10 p.m. DON bected to perform hand hygiene ange. Dressing Change - Clean,	F 4	141	R#49- The soiled laundry hamper of placed inside the room and staff cator R#49 were re-educated on perfhand hygiene before leaving the room. All residents have the potential to be affected by a practice deficient in the area. All NAR and Nursing staff were re-educated on hand hygiene and infection control precautions. DON/designee will conduct observe audits of hand hygiene at random to throughout the 24 hour period. A minimum of 2 audits per week for 2 weeks, then 2 audits/week x2 week once weekly for 2 weeks and monto thereafter. DON/designee will conduct observe audits of wound care to ensure appropriate infection control technicare used, 2Xweek x2, then 2 audits x2 weeks, then once weekly for 2 wand monthly thereafter. Audit results will be brought to the committee for review and further recommendation. Completion date for F 441 is 12/13.	aring orming orming om. The ational imes Ational ques solveeks QAPI	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED				
		245399	B. WING			11/	03/2016		
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				120	REET ADDRESS, CITY, STATE, ZIP CODE 00 FIRST AVENUE NORTHEAST TTLE FALLS, MN 56345				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	wound with prescril - Apply prescribed - Apply dressings a - Remove gloves a	of bed and discard and discard and clean gloves. Cleanse bed solution if ordered. The medications as ordered and secure with tape and wash hands.	F 4	141					
	R49 had a clostridium difficile (C. difficile) infection, and the facility did not implement appropriate infection control precautions. The Center for Disease Control (CDC) guidelines for health care facilities directed the following when caring for residents with a C. Difficile infection: Isolate patients with C. difficile immediately. Wear gloves and gowns when treating patients with C. difficile, even during short visits. Hand sanitizer does not kill C. difficile, and although hand washing works better, it still may not be sufficient alone, thus the importance of gloves. Clean room surfaces thoroughly on a daily basis while treating a patient with C. difficile and upon patient discharge or transfer. Supplement cleaning as needed with use of bleach or another EPA-approved, spore-killing disinfectant. R49's diagnosis list identified enterocolitis due to clostridium difficile (a spore-forming bacteria that can cause swelling and irritation of the large intestine, or colon. This inflammation, known as colitis, can cause diarrhea, fever, and abdominal cramps). Progress note dated 10/21/16, lab tested positive for clostridium difficile on 10/13/16. R49's significant change Minimum Data Set (MDS) dated 10/20/16, indicated R49 had moderately impaired cognition, required extensive								

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		245399	B. WING _		11	/03/2016
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	dirty linen hamper of During observation nursing assistant (Normowed her potential outside of R49's room the dirty linen hamper walked down hall a bathroom by nursing with soap and water During observation occupational therapand removed her poutside R49's room hamper outside R49's room hamper outside R49's room outside of R49's room. OT-A further outside of R49's room. OT-A further outside of R49's room licensed practical mask, and gloves puring observation licensed practical mask, and gloves puring o	of bowel. on 10/31/16, at 11:30 p.m. a was outside R49's room. on 11/02/16, at 1:12 p.m. NA)-A exited R49's room and tially contaminated gown om, and placed the gown in oer outside R49's room. NA-A bout 40 feet away entered g station, and washed hands	F 44	41		

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245399	B. WING	i		11/(03/2016
	PROVIDER OR SUPPLIER	3		1	STREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465 SS=D	stated she removed R49's room, and stated hathroom by nurse's During interview on stated R49 was in its before entering R45 gloves and a gown. mask and gloves ar trash can, hands ar exiting, and gown is outside of R49's roo her hands using the soap and water price During interview on director of nursing stated hat soap and water before dirty laundry har R49's room. The facility policy 6. Control Program da precautions are insistymptomatic C. difficultion Precaution 8/15 directs staff before antiseptic soap and maintained in the roperiod. Remove the hygiene before leave environment.	11/20/16, at 2:30 p.m. NA-A d her mask and gloves in ated she washed hands in s station. 11/02/16, at 1:17 p.m. NA-B solation for C. difficile, and 9's room you put on a mask, When exiting R49's room the re removed, and thrown in re washed in room before s placed in dirty hamper om. NA-B stated she washes a hand sanitizer, instead of or to leaving room. 11/03/2016, 11:02 a.m. the stated her expectations for C. hands should be washed with ore leaving R49's room and mper should be kept inside of .0 Infection Prevention and ated 1/16, directed Contact tituted for residents with ricile infection. Policy 6.14 hs-Transmission Based dated a sure that an adequate supply and paper towels are foom during the isolation agown and perform hand		441			12/13/16
		ovide a safe, functional, ortable environment for					

-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 465	by: Based on observa review, the facility f equipment for 2 or wheelchair and foo Findings Include: R23's quarterly Mir 10/5/16, indicated I mobility. During observation presented with mul fabric of her left wh extended length wi foam padding was During interview or assistant (NA)-E st cracks but should s to R23's armrests. not be able to be cl staff should have fi	Ithe public. NT is not met as evidenced tion, interview, and document ailed to maintain resident care 2 residents (R23, R33) whose t pad were is disrepair. Immum Data Set (MDS) dated R23 used a wheelchair for on 11/1/16, at 6:47 p.m. R23 tiple long cracks in the black reelchair armrest. The cracks se along the armrest and white visible through the cracks. In 11/1/16, at 7:10 p.m. nursing ated she was not aware of the staff should be paying attention NA-E stated the armrest would eaned well, and further stated, lled out a maintenance slip to	F 46	,	s were chair. emoved hairs have a deficient haintaining wheelchair ee will random		
	different chair. R33's annual MDS used a wheelchair limitations in R33's During observation presented with a bl 10 inches (in) by 17	dated 9/28/16, indicated R33 for mobility with functional lower extremities. on 10/31/16, at 1:58 p.m. R33 ue rectangular pad, measuring 7 in, under his feet and ankles wheelchair. The pad, located		Audit results will be brought to a committee for review and further recommendation. Completion date for F 465 is 12	er		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 465	between R33's leg both sides with duc Upon further inspect the duck tape was with bottom and bac rested his ankles or pad had ripped and the pad together. Not o ensure R33's leg foot pedals. She also his feet on the duck noticed the tape, are to for it to be repaired. During interview on of maintenance star repair requests for armrests. The DOM maintenance slips frould be fixed. During interview on registered nurse (R staff to fill out a maintenance star requipment in disreptixed. An facility policy enfundated, instructing	rests, appeared to be torn on k tape covering the torn areas. Ition on 11/3/16, at 10:51 a.m. wrapped completely around k of the cushion while R33 in the tape. NA-F stated the lithe duck tape was holding A-F further stated the pad was is would not catch between the so stated R33 should not have at tape, someone should have ind filled out a maintenance slip ed. 11/3/16, at 1:50 p.m. director ted he had not received any the wheelchair pads or the stated staff should fill out for equipment in disrepair so it intenance form for care pair so the equipment could be order to maintenance order to maintain "equipment"	F 46	55		

F5399025

Printed: 11/08/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 03 - EAST BUILDING

(X3) DATE SURVEY COMPLETED

245399

B. WING

11/04/2016

NAME OF PROVIDER OR SUPPLIER

LITTLE FALLS CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

LITTLE FALLS CARE CENTER			FALLS, MI	N 56345	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULA' OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K 000		
	FIRE SAFETY				
	A Federal Life Safety Code Survey was conducted by the Minnesota Departmer Public Safety, State Fire Marshal Division time of this survey, the Little Falls Care 2016 East Building Addition was found i substantial compliance with the requirer participation in Medicare/Medicaid at 42 Subpart 483.70(a), Life Safety from Fire 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Code (LSC), Chapter 19 Existing Healt	on. At the Center n ments for CFR, and the Safety	N		
	The facility was inspected as two buildir Little Falls Care Center consists of two separated by a 2 hour fire separation. It oas the East Building Addition is a 1 story without a basement built in 2016 and was determined to be Type II(111) construct Building 03, the Mechanical Room build story building without a basement and very determined to be Type II(111) construct Building 03 was built under the 2000 ed National Fire Protection Association (NF Standard 101 Life Safety Code and Buil was built to the 2012 edition of National Protection Association (NFPA) Standard Safety Code the two buildings were inspected.	buildings Building y building as ion. ling is a 1 vas ion. Since ition of the FPA) lding 04 Fire d 101, Life			
	The facility is divided into 3 smoke com with 1-hour and 2-hour fire barriers. The fully protected with an automatic sprink installed in accordance with NFPA 13 T Standard for the Installation of Sprinkle 1999 edition. The facility has a fire alarm	facility is ler system he Systems			
LABORATO	DRY DIRECTOR'S OR PROVIDER/SUPPLIER REPRES	ENTATIVE'S SIC	MATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

Printed: 11/08/2016 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 03 - EAST BUILDING COMPLETED 245399 B. WING 11/04/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER 1200 FIRST AVENUE NORTHEAST **LITTLE FALLS, MN 56345** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 Continued From page 1 K 000 which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition, All sleeping rooms have smoke detection and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2015 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.

Printed: 11/08/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - MECHANICAL ROOMS (X3) DATE SURVEY COMPLETED

245399

B. WING

11/04/2016

NAME OF PROVIDER OR SUPPLIER

LITTLE FALLS CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1200 FIRST AVENUE NORTHEAST

LITTLE FALLS CARE CENTER		11	FALLS, M	N 56345	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K 000		
	FIRE SAFETY				
	A Federal Life Safety Code Survey was conducted by the Minnesota Departmer Public Safety, State Fire Marshal Division time of this survey, the Little Falls Care 2016 East Building Addition was found is substantial compliance with the require participation in Medicare/Medicaid at 42 Subpart 483.70(a), Life Safety from Fire 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Code (LSC), Chapter 18 New Health Compared to the Minnesota Protection Association (NFPA) Standard 101, Life Code (LSC), Chapter 18 New Health Code (LSC)	on. At the Center n ments for cFR, e, and the Safety			
T T	The facility was inspected as two building Building 04 - The Mechanical Room bu 1 story building without a basement and determined to be Type II(111) construct Building 03 was built under the 2000 ed National Fire Protection Association (NI Standard 101 Life Safety Code and Bui was built to the 2012 edition of National Protection Association (NFPA) Standard Safety Code the two buildings were inspected.	Ilding is a I was ion. Since lition of the FPA) Iding 04 I Fire d 101, Life			
	The facility is fully protected with an aut sprinkler system installed in accordance NFPA 13 The Standard for the Installati Sprinkler Systems 1999 edition. The fa fire alarm system which includes corrid detection throughout and in all common installed in accordance with NFPA 72 "National Fire Alarm Code" 1999 edition sleeping rooms have smoke detection hazardous areas have automatic fire deaccordance with the Minnesota State F	e with ion of cility has a or smoke n areas, The . All and etection in			
LABORATO	DRY DIRECTOR'S OR PROVIDER/SUPPLIER REPRES	ENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 11/08/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 04 - MECHANICAL ROOMS COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** 245399 B. WING _ 11/04/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1200 FIRST AVENUE NORTHEAST LITTLE FALLS CARE CENTER LITTLE FALLS, MN 56345 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 | Continued From page 1 2015 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted November 22, 2016

Ms. Amy Walker, Administrator Little Falls Care Center 1200 First Avenue Northeast Little Falls, MN 56345

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5399027

Dear Ms. Walker:

The above facility was surveyed on November 4, 2016 through November 4, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation 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 144A.10. 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.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 Department of Health orders being submitted to you electronically. 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 Nursing Homes.

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

Little Falls Care Center November 22, 2016 Page 2

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 are the Suggested Method of Correction and 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.

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. 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 Kathy Lucas, Unit Supervisor at (320) 223-7343.

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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00382	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	{	ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correspursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/02/16 **Electronically Signed**

TITLE

STATE FORM 6899 W5XP11 If continuation sheet 1 of 58

Minnesota Department of Health

IVIII II ICSC	ta Department of Tie	aitii				
-	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00382	B. WING		11/0	3/2016
NAME OF I		CTDEET ADI	DDECC OITY (STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LITTLE F	ALLS CARE CENTER	8		NORTHEAST		
		LITTLE FA	ALLS, MN 50	5345		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG	TIEGOE/TIOTTI OTTE	oo ibertii Tiiva iivi Oriwixi loivi	IAG	DEFICIENCY)	111/11 =	
2 000	Continued From pa	ge 1	2 000			
	Department of Heal	Ith orders being submitted to				
		Although no plan of correction				
		ate Statutes/Rules, please				
		rected" in the box available for				
		indicate in the electronic				
		cess, under the heading				
		e date your orders will be				
		ectronically submitting to the				
	Minnesota Departm					
		November 3rd 2016,				
		epartment's staff, visited the				
		the following correction				
		Please indicate in your				
		orrection that you have				
		ers, and identify the date when				
	they will be complet					
		ent of Health is documenting				
		Correction Orders using				
		g numbers have been				
		ota state statutes/rules for				
		e assigned tag number				
		eft column entitled "ID Prefix				
		tute/rule out of compliance is				
		ary Statement of Deficiencies"				
		es the "To Comply" portion of				
	•	This column also includes				
		are in violation of the state				
		tement, "This Rule is not met				
		ollowing the surveyors findings				
		Method of Correction and				
	Time period for Cor					
		complaint H5399021 was				
		nd not to be substantiated.				
		RD THE HEADING OF THE				
	FOURTH COLUMN					
		N OF CORRECTION." THIS				
		ERAL DEFICIENCIES ONLY.				
		R ON EACH PAGE.				
		DUBEMENT TO SUBMIT A				

Minnesota Department of Health

PLAN OF CORRECTION FOR VIOLATIONS OF

STATE FORM 6899 W5XP11 If continuation sheet 2 of 58

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE	SURVEY LETED
71140 1 12/114	OF CONTILECTION	IDENTIFICATION NOMBER.	A. BUILDING:		CONI	LLTLD
		00382	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	2		NORTHEAST		
			ALLS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	MINNESOTA STAT	E STATUTES/RULES.				
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment		2 540			12/13/16
	conduct a compreh resident's needs, w capability to perform significant impairments of the comprehensive resused to develop, recomprehensive resused to develop, recomprehensive play 4658.0405. Subp. 2. Informational comprehensive resinclude at least the A. medically demedical history; B. medical state C. physical and D. sensory and E. nutritional state G. mental and H. discharge pl. dental condit J. activities pot K. rehabilitation L. cognitive state M. drug therapy N. resident presidents.	ion; ential; n potential; ttus; r; and ferences.				
	This MN Requirements	ent is not met as evidenced				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING: 00382 B. WING	11/0	SURVEY LETED 3/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST	CTION DULD BE	3/2016
LITTLE FALLS CARE CENTER 1200 FIRST AVENUE NORTHEAST	OULD BE	
TITLE FALLS CARE CENTER	OULD BE	
LITTLE FALLS CARE CENTER	OULD BE	
LITTLE FALLS, MN 56345	OULD BE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETE DATE
2 540 Continued From page 3 2 540		
Based on interview and document review, the facility failed to comprehensively assess for the use of psychotropic (mood altering) medication during the assessment reference dates (ARD) for 2 of 5 residents (R9, R44) reviewed for unnecessary medications. Findings include: R9's admission Minimum Data Set (MDS) dated 10/16/16, indicated R9 had diagnoses of dementia, anxiety disorder and depression. The MDS also indicated R9 was taking an antianxiety the last seven days and antidepressant medication the last seven days. R9's psychotropic drug use Care Area Assessment worksheet was never completed. R9's Admission Observations (where the facility documents the admission CAAs started 10/9/16, and completed 10/14/16, did not contain a comprehensive psychotropic drug assessment. R44's significant change MDS dated 10/19/16, indicated R9 was taking an antipsychotic the last seven days, an antianxiety the last seven days and antidepressant medication the last seven days and antidepressant medication the last seven days. R9's psychotropic drug use CAA was initiated, however, the assessment worksheet was never completed. B#44- a comprehensive psychotropic assessment was completed. R#44- a comprehensive psychotropic medications have a potential to affected by a deficient practice in affected by a deficient practic	annually ropic drug otropic drug c be in this ing psych ated on opic ve a sment	
was never completed. R44's General Nurses Observations (where the facility documents the CAAs after admission) started 10/19/16, and completed 10/19/16, did not contain a comprehensive psychotropic drug x2 weeks, then once weekly for and then monthly thereafter. Audit results will be brought to t committee for review and further recommendation.	he QAPI	

Minnesota Department of Health STATE FORM

6899 If continuation sheet 4 of 58 W5XP11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00382	B. WING		11/	03/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	1200 FIRS	DRESS, CITY, S' ST AVENUE N ALLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 540	During interview on registered nurse (R responsible for commesidents. RN-C stapsychotropic drug to period for R9 and F she never complete CAA's on any residing period unless it was month regardless of RN-C could not procomprehensive psychotropic drug (Completed on admifacility is not sure wwarranted. RN-C allutilize the worksheer electronic MDS recrusted assessments under observations. During interview on director of nursing stassessment for psychotropic drug (Completed on admifacility is not sure wwarranted. RN-C allutilize the worksheer electronic MDS recrusted to be command with a signification of nursing stassessment for psychotropic drug (Completed on admission, annual of the facility policy P10/1/15, did not add assessment would admission, annual of the facility policy pregarding completic comprehensive residents.	a 11/3/16, at 2:25 p.m. and a 11/3/16, at 4:01 p.m. the stated a comprehensive was not estated that a 11/3/16, at 4:01 p.m. the stated a comprehensive was not estated a comprehensive was not estated and and a 11/3/16, at 4:01 p.m. the stated and and and and and and and and and an				

Minnesota Department of Health

STATE FORM 6899 W5XP11 If continuation sheet 5 of 58

Minneso	<u>ta Department of He</u>	alth				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00382	B. WING		11/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	ALLS CARE CENTER	₹	T AVENUE I	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 5	2 540			
		nges. The Quality Assessment A) committee could do nsure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.0408 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			12/13/16
	comprehensive plate objectives and time long- and short-term and mental and psylidentified in the contassessment. The compassion of the contast include the includ	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, who social needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observati review, the facility for comprehensive car continuous positive breathing machine used a CPAP. In acc develop a compreh included range of m	ent is not met as evidenced on, interview and document ailed to develop a e plan for the use of a airway pressure (CPAP) for 1 of 1 resident (R40) who ddition, the facility failed to ensive care plan which notion (ROM) services for 1 of eviewed for a restorative		LFHS develops comprehensive Caplans to describe services to attain maintain the resident shighest practicable physical, mental and psychosocial well-being. R#40- care plan and NAR group swere updated to include CPAP to be placed when resident requests. R#23 care plan was updated to include Restorative ROM Program.	n or heets be	
		orinted on 11/03/16, indicated cluded chronic respiratory		All residents on CPAP and that red ROM have the potential to be affect		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 6 of 58 W5XP11

Minnesota Department of Health

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE	
71110 1 12711	OF CONTRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		CONT	
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
LITTLE I	FALLS CARE CENTER	?	T AVENUE I LLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 6	2 560			
	failure with hypoxia oxygen reaching the spontaneous pneur pulmonary disease unspecified, obstruct where a person has breathing or shallow R40's quarterly Min 10/24/16, indicated impairment, and util R40's care plan dat at risk for shortness directed nursing sta (HOB), monitor for liters per nasal candirection for CPAP R40's physician ord R40 was to have C a day (day, evening bed. During interview on member (F)-A state should be on when R40 was observed cannula at 3 liters on ight stand. During observations 11/1/16, at 6:50 p.m was in bed sleeping cannula on and CP.	(deficiency in the amount of e body's tissues), primary nothorax, chronic obstructive (lung condition - COPD) ctive sleep apnea (a disorder one or more pauses in w breathing while sleeping). imum Data Set (MDS) dated R40 had severe cognitive ized oxygen (O2) therapy. ed 3/06/16, identified R40 was of breath (SOB), and tiff to elevate head of bed SOB, and maintain O2 at 3-4 nula. The care plan lacked use. ders dated 10/04/16, indicated PAP machine applied 3 times of times in night) and anytime lying in 10/31/16, at 1:37 p.m. family od R40's CPAP machine he was sleeping or napping. sleeping with O2 per nasal on, and CPAP sitting on R40's on 10/31/16, at 2:25 p.m., n., 11/2/16, at 7:10 a.m., R40 of with HOB elevated, O2 nasal AP on nightstand. 11/02/16, at 9:49 a.m. N)-A stated R40's CPAP		a deficient practice in this area. Nursing staff involved care plan documentation were re-educated oprocess of completing a care plan CPAP and restorative ROM progracare plans for residents with a reserviewed and revised prn. DON or designee will perform chat to ensure care plans are accurate CPAP and Restorative Rom programinimum of 3 audits per week for weeks, then 2 audits/week x2 wee once weekly for 2 weeks and then thereafter. Audit results will be brought to the committee for review and further recommendation.	for ms. torative P were rt audits for ams. A 2 ks, then monthly	

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	2	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 7	2 560			
	During interview on 11/03/16, at 11:00 a.m. director of nursing (DON) stated R40's CPAP should be on the care plan.					
	R23's quarterly MDS dated 10/5/16, identified R23 had moderate cognitive impairment and no functional limitation in ROM in both upper and lower extremities.					
	physical therapist (I therapy when she we had been discharge	11/2/16, at 12:07 p.m. PT)-A stated R23 had received was admitted to the facility and ed with therapy or upper and lower extremity				
	group sheet identif	ed facility nursing assistant ied R23 was on a restorative INP) but did not list ROM				
	needing assistance	ted 1/31/16, indicated R23 with mobility. It did not identify restorative program or				
	stated R23 was to r days a week. RN-A were assessed qua	11/3/16, at 1:38 p.m. RN-A receive ROM once a day six stated R23's ROM abilities arterly along with updating the roup sheets and care plan.				
	stated she was in the care plans to reflect	11/3/16, at 3:55 p.m. RN-C ne process of updating the t restorative programs. RN-C plan did not contain a n and should.				
		11/3/16, at 4:16 p.m. the DON spect a restorative ROM				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00382	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	1	T AVENUE I	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	program to be on the A facility policy entity 11/8/15, directed responded to the carnurse manager. SUGGESTED MET The director of nurse staff to develop a content of the c		2 560			
2 565	Plan of Care; Use Subp. 3. Use. A comust be used by all care of the resident This MN Requirement by: Based on observation review, the facility frequency assistance of the residents with a restorative proprovide services pressure ulcer for 1.	omprehensive plan of care personnel involved in the involved inv	2 565	LFHS ensure the resident s oral s reflected on the individual plan of c R# 7 care plan and NAR group shoupdated to reflect the absence of r teeth or dentures. All residents care plans were rev	eet was natural	12/13/16

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMPI	
		00382	B. WING		11/0:	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		<u> </u>
LITTLE F	FALLS CARE CENTER	?	T AVENUE I	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 9	2 565			
	placement of a gastrostomy tube (G-tube) as directed by the care plan for 1 of 1 resident (R40) who had a G-tube. Findings Include:			ensure the care plan reflects their status and oral hygiene needs.		
				Nursing staff were re-educated on assessing oral status and process inform Nurse Manager who is in clupdating care plans.	to	
10/5/16, identified a impairment and ne		imum Data Set (MDS) dated moderate cognitive eded extensive assistance of both in her room and outside.		DON or designee will perform care audits to ensure care plans regard resident's oral status are complete minimum of 3 audits per week for	ing the e. A 2	
	R23's current care plan dated 1/31/16, directed staff to walk R23 resident in order to prevent a decline in ambulation.			weeks, then 2 audits/week x2 wee once weekly for 2 weeks and then thereafter.		
	group sheet, identif	d facility nursing assistant ied R23 was on a restorative NP) and directed staff to walk		Audit results will be brought to the committee for review and further recommendation.	QAPI	
	was seated in her w (NA)-D was observe R23's wheelchair a	on 11/1/16, at 5:32 p.m., R23 wheelchair. Nursing assistant ed to put foot pedals onto nd proceeded to push R23 to supper. No attempt or offer with R23.				
	stated the nursing a R23 in her wheelch	11/2/16, at 8:00 p.m. NA-D assistants typically pushed air to meals and further stated much as she used to.				
	was again being pu	on 11/2/16, at 8:05 a.m. R23 shed in her wheelchair from nto the dining room for				
		11/2/16, at 7:44 a.m. licensed N)-E stated R23 was on a				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00382	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	{	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 10	2 565			
	restorative program but did not walk that morning due to knee pain.					
	was seated in her w transferred from the	on 11/2/16, at 11:52 p.m. R23 wheelchair. R23 had been be bed into the wheelchair by 3 was then observed to again heelchair to lunch.				
	stated R23 had refustated R23 does no	11/2/16, at 12:02 p.m., NA-G used to walk to lunch. NA-G of ever walk to meals and was on a restorative ambulation				
	physical therapist (I therapy when she w had been discharge recommendations f	or a restorative ambulation ed R23's goals was to				
	stated R23 used to room changed, as I to the dining room. walk all the way frod dining room, but the	11/3/16, at 7:46 a.m. NA-H walk to meals before her ner previous room was closer NA-H did not think R23 could m her current room to the bught staff could attempt to was closer to the dining room.				
	registered nurse (R assistants were res and thought R23's i program was being ambulate to the bat thought the ambula	11/3/16, at 1:38 p.m. N)-A stated the nursing ponsible for walking with R23 restorative ambulation done as she often saw R23 hroom and in her room. RN-A tion documentation was not 23's walking and staff needed				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE I	FALLS CARE CENTE	R	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 11	2 565			
	of nursing (DON) s R23's ambulation p	n 11/3/16, at 4:16 p.m. director tated the inconsistency in program was due to press by the nursing assistants.				
	10/12/16, identified ulcers, had one sta unstageable pressi It also identified pre	uled assessment MDS dated IR2 was at risk of pressure age 2 pressure ulcer and one ure ulcer, and none worsening. Essure reducing device for the R2 was on a turning and am.				
		ed 10/31/16, identified staff tensive assistance as follows:				
	in bed Assist of two to ta - Assistance of two - R2 had a pressur with an intervention					
	be repositioned eve	eare sheet indicated R2 was to ery two to three hours. It also es, float heels, and air				
	was lying in bed on	on 11/2/16, at 7:06 a.m. R2 her right side. Both heels irectly on the mattress, not				
	During observation	on 11/2/16, at 7:39 a.m. the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00382	B. WING		11/0	3/2016
				TATE, ZIP CODE IORTHEAST 3345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	DON and RN-C end dressing changes to right medial buttock R2's heels were not assisted to place a float the heels off the On 11/3/16, at 8:54 began. R2 was obsite in the dining room, was observed in oppoach half of the slip heel, resting on the of the foot rest. At the activity room, where we will be to assisted R2 to the total the left foot. At 11:1 the activity room, at R2 asked to use the total assist. Continuo time. For 2 hours at in her wheelchair, wheel resting on the staff did not offer to observed to reposit. During interview on denied being aware When she helped to the pillow had been knees, and R2 did overified R2's heels mattress at this tim.	tered R2's room to perform of the pressure ulcers on her cand left heel. RN-C stated of floated in bed. RN-C pillow beneath R2's legs to be bed. a.m. continuous observation served sitting in her wheelchair eating breakfast. R2's left foot bened back slipper, with the oper and foot, including the foot rest, and the front half off 9:56 a.m. R2 was assisted to be ith left foot observed 28 a.m. R2 remained in the effee. Activity director (AD) table, making no offer to adjust 10 a.m. AD assisted R2 out of find to her room. At 11:18 a.m. be bathroom, and NA-F entered us observation ended at this and 24 minutes, R2 remained with her foot observed with the foot rest. During this time, or reposition and R2 was not ion independently. 11/2/16, at 7:24 a.m. NA-A of any skin issues with R2. The proposition R2 in the morning, a kicked out from beneath her not want it replaced. NA-A were resting directly on the e, not being floated.				
		C verified R2's heels were not g when she entered to do				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	₹	ST AVENUE N ALLS, MN 56			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 565	Continued From pa	ge 13	2 565			
	happens. RN-C stareport any changes the RNs. During interview on stated R2's heel sh	as not aware of how often this ated staff are expected to or non-compliance to one of 11/3/16, at 1:38 p.m. RN-C ould not be resting directly on aff education was provided.				
	R40's care plan dat check placement of medications via the orders R40's physician ord G-tube feeding Jev hour times 24 hours indicate he was to r G-tube with 30 cubi before and after medicate puring observation LPN-A prepared to	ed 6/16/16, directed nurses to G-tube, administer G-tube following physician's ler dated 10/4/16, directed ity 1.2 at 65 milliliters (ml) per s. R40's medication orders eceive his medications via c centimeters (cc) flushes				
	syringe, placed it in water, withdrew 60 R40's G-tube port, wipe. LPN-A placed G-tube port and attracts of water, and many check for G-tube plauscultation prior to During interview on stated R40 had a G-tube placement prinfusion of Jevity. During observation LPN-B prepared many medication in cup to G-tube. LPN-B turn	to a graduate container of ccs of tab water, opened and cleaned port with alcohol I the tip of the syringe into the empted to flush tube with 60 let resistance. LPN-A did not accement by aspiration or a starting the Jevity infusion. 10/31/16, at 2:25 p.m. LPN-A litube and did not check for orior to flush or starting on 11/01/16, at 7:37 p.m. edication and placed in administer through R40's ed off feeding pump, libing, and placed the 60 ccs				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE	SURVEY
AND I LAN OF CONTILOTION		BENTI IOATION NOMBER.	A. BUILDING:		GOIVII LETED	
		00382	B. WING		11/0	3/2016
NAME OF PROVIDER OR SUPP	IER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE FALLS CARE CE	TEI	R		NORTHEAST		
			ALLS, MN 5	T		
PREFIX (EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
distilled water is met resistance placement by a entered R40's is LPN-B with flust check for G-tuke auscultation. List syringe with a right of G-tuke and addition check for G-tuke auscultation properties to water flower policy and of During interview stated she had prior to water flower policy and of During interview stated the G-tuke placement by a flushing, medicated the goals, and states the goals, and the also indicated the also	G-t :	sube port, and poured 60 ccs of syringe to flush via gravity and N-B did not check for G-tube ration or auscultation. RN-A in and attempted to assist gethe G-tube. RN-A did not lacement by aspiration or B used a different 60 cc ow tip and was able to flush ster medication. LPN-B did not lacement by aspiration or administering medications. In 11/01/16, at 8:15 p.m. LPN-B checked G-tube for placement or administering medication or plan. In 11/01/16, at 8:20 p.m. RN-A needed to be checked for ation or auscultation prior in administration, and starting stated R40's care plan dated	2 565			

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SUGGESTED METHOD OF CORRECTION:

Minnesota Department of Health

Millineso	Minnesota Department of Health						
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	-E I EU	
		00382	B. WING	B. WING		2/2016	
		00362	2		11/0	3/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LITTLE F	ALLS CARE CENTER	?	_	NORTHEAST			
	0.0000000000000000000000000000000000000		LLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 15	2 565				
	a system to educate monitoring system to care as directed by	sing or designee could develop e staff and develop a to ensure staff are providing the written plan of care. R CORRECTION: Twenty-one					
2 570	. , -	5 Subp. 4 Comprehensive ion	2 570			12/13/16	
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's legal representative at least seven days of the revision of resident assessment required					
	by: Based on observati review, the facility for the presence of der	ent is not met as evidenced on, interview, and document ailed to revise the care plan for ntures/natural teeth for 1 of 3 ewed for dental services.		LFHS ensure the resident s oral s reflected on the individual plan of c R# 7 care plan and NAR group shoupdated to reflect the absence of r teeth or dentures.	eare.		
		ım Data Set (MDS) dated lo dental concerns or		All residents care plans were revensure the care plan reflects their status and oral hygiene needs.			
	Facility General Nu	rses's Observation notes		Nursing staff were re-educated on			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00382	B. WING		11/03/2016	
	PROVIDER OR SUPPLIER	1200 FIRS		STATE, ZIP CODE NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE	
2 570	dentures, which she General Nurses's C 7/22/16 and 8/19/16 lower dentures, how missing. General Nurses's C 10/20/16, indicated missing for months natural teeth. An undated, un-title group sheet, identif the top of her mouth her teeth. R7's current care pl directed staff to bru and to clean R7's d During observation did not have any tee During dining obser R7 was again eden Nursing assistant (I stated R7 did not w natural teeth. During interview on stated R7 sometime thought she had na un-titled facility care teeth. During interview on	cated R7 had upper and lower edid not wear. Observation notes dated 6, indicated R7 had upper and wever, the dentures were Observation note dated R7's dentures had been and indicated R7 had no ed facility nursing assistant ied R7 had partial dentures on hand directed staff to brush lan, last revised 8/14/16, sh R7's own existing teeth entures overnight. on 10/31/16, at 2:22 p.m. R7 eth or dentures in her mouth. Evation on 11/1/16, at 6:14 p.m. tulous while eating supper. NA)-D assisted R7 to eat and ear dentures and had no 11/2/16, at 8:19 a.m. NA-I es refused oral cares but tural teeth. NA-I looked at an e sheet to confirm R7 had 11/2/16, at 8:50 a.m. licensed N)-A stated R7 had natural	2 570	assessing oral status and process inform Nurse Manager who is in cupdating care plans. DON or designee will perform care audits to ensure care plans regard resident's oral status are complete minimum of 3 audits per week for weeks, then 2 audits/week x2 wee once weekly for 2 weeks and then thereafter. Audit results will be brought to the committee for review and further recommendation.	e plan ling the e. A 2 eks, then monthly	

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						DATE SURVEY COMPLETED	
			A. BOILDING.				
		00382	B. WING		11/03/2016		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LITTLE F	ALLS CARE CENTER	₹	T AVENUE I ALLS, MN 50	NORTHEAST 6345			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 570	Continued From pa	ge 17	2 570				
	registered nurse (R teeth and used to h often threw them in them home from th R7's care plan had	11/2/16, at 10:15 a.m. N)-A stated R7 had no natural ave dentures. However, R7 the trash, so family removed e facility. RN-A further stated not been revised because R7 just not in the facility" and may some point.					
	The director of nurs develop, review, an procedures to ensu care plans. The dire designee could edu the policies and pro	HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re compliance with revision of ector of nursing (DON) or locate all appropriate staff on locedures. The director of esignee could develop to ensure ongoing					
	TIME PERIOD FOR (21) Days	R CORRECTION: Twenty-one					
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			12/13/16	
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the custodial care.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ang home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.					

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Minnesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00382	B. WING		11/0:	11/03/2016	
NAME OF PROVIDER OR SUPPLI	ER STREET AD	DRESS, CITY,	STATE, ZIP CODE			
LITTLE CALLO CADE OFN	1200 FIRS	ST AVENUE	NORTHEAST			
LITTLE FALLS CARE CEN	LITTLE F	ALLS, MN 5	6345			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
2 830 Continued From	page 18	2 830				
by: Based on observeriew, the facility positive airway promachine as direct the use of the Clutilized a CPAP. re-assess and depositioning for 1 observed to learn Findings include R40's undated Findicated R40's respiratory failure amount of oxygen primary spontaneobstructive pulmed condition-COPD apnea (a disorder more pauses in while sleeping). R40's General New serves as the care 10/19/16, indicated sleeping 8-9 hours R40's quarterly 10/24/16, indicated impairment, utilizereeived extensi	ace Sheet printed on 11/03/16, diagnoses included chronic with hypoxia (deficiency in the present reaching the body's tissues), eous pneumothorax, chronic onary disease (lung) unspecified, obstructive sleep or where a person has one or preathing or shallow breathing urse's Observation Note, which re area assessment (CAA) dated ed R40 was assessed as rs a night and 2-3 naps daily. Minimum Data Set (MDS) dated ed R40 had severe cognitive and control of the property of the pr		LFHS ensures each resident receicare and services to attain or main their highest practicable physical, and psychosocial well-being. R#40- New physician orders were obtained for CPAP use. R#23- was re-assessed by occupatherapy and a new wheelchair was provided. All residents who utilize a CPAP autilize wheelchairs have the potent affected by a deficient practice in tarea. Nursing staff were re-educated on of CPAP and documentation of ref CPAP. All Nursing staff were also re-educated on wheelchair position and the need to report to the Nursing Manager if repositioning is unsucced. DON or designee will conduct rand observational audits for wheelchair positioning. A minimum of 3 audit week for 2 weeks, then 2 audits/wweeks, then once weekly for 2 weeks then monthly thereafter. DON or designee will conduct rand observational audits for CPAP use minimum of 3 audits per week for weeks, then 2 audits/week x2 weeks, then 2 audits/weeks, then 2 aud	ational ational shall be shall		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	₹	ST AVENUE ALLS, MN 5	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
2 830	Continued From page 19		2 830			
	R40's care plan dated 3/06/16, identified R40 was at risk for shortness of breath (SOB), and directed staff to elevate head of bed (HOB), monitor for SOB, and maintain O2 at 3-4 liters per nasal cannula. Care plan lacked direction for CPAP use.			once weekly for 2 weeks and then thereafter. Audit results will be brought to the Committee for review and further recommendation.		
	R40 was to have C	lers dated 10/04/16, indicated PAP machine applied 3 times , night) and anytime lying in				
	R40's physician note dated 10/24/16, indicated R40's wife was concerned about the hypoxic event R40 had on 10/23/16. Physician order was to continue with same plan of care.					
	R40's electronic Treatment Administration Record (ETAR) dated October 2016, directed nurses to apply CPAP anytime lying in bed, and initial each shift. The ETAR lacked indication if CPAP was applied, refused, or removed.					
		s from 10/01/16, through dicate if or whether R40 had reatment.				
	member (F)-A state should be on when At that time, R40 wa	10/31/16, at 1:37 p.m. family ed R40's CPAP machine he was sleeping or napping. as observed sleeping with O2 at 3 liters on, and CPAP sitting d.				
	was sleeping in bed mouth with O2 on a HOB elevated and stand. Licensed pra	on 10/31/16, at 2:25 p.m. R40 d, and breathing through his at 3 liters per nasal cannula, CPAP was sitting on night actical nurse (LPN)-A was in d a difficult time arousing R40				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOLEBING.			
		00382	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	2	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 20	2 830			
	and asked him if he	e was sleeping at night. LPN-A ge that R49 was not utilizing				
		on 11/01/16, at 6:50 p.m. R40 g with HOB elevated, O2 nasal AP on nightstand.				
		on 11/01/16, at 7:28 p.m. R40 g with HOB elevated, O2 nasal AP on nightstand.				
		on 11/02/16, at 7:10 a.m. R40 g with HOB elevated, O2 nasal AP on nightstand .				
		on 11/02/16, at 8:55 a.m. R40 g with HOB elevated, O2 nasal AP on nightstand.				
	registered nurse (F CPAP since admiss CPAP machine any the night, and at his documentation on t CPAP was applied, stated R40 refused would be charted in	a 11/02/16, at 9:49 a.m. RN)-A stated R40 had his sion on 2/06/16, and used the time he was sleeping, during a request. RN-A stated the ETAR does not reflect if the refused, or removed. RN-A CPAP at times, and refusals in the nursing progress notes. Sould expect to see the CPAP				
	licensed practical n would wear the CP, after each nebulize saturations are belo liked to wear the CI LPN-A stated at that	11/02/16, at 10:13 a.m. hurse (LPN)-A stated R40 AP when he was feeling SOB, or treatment, and if O2 bw 90%. LPN-A stated R40 PAP when he was napping. at time the documentation on appleted for the whole shift and				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 11/0	0,2010
LITTLE F	FALLS CARE CENTER	1		NORTHEAST		
		LITTLE FA	ALLS, MN 50		ONI	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 21		2 830			
	did not reflect if the CPAP was applied, refused, or removed. Review of the ETAR indicated O2 saturation rates were normal at 90 or above.					
	During interview on 11/03/16, at 11:00 a.m. the director of nursing (DON) stated R40's CPAP should be applied as directed. The DON stated CPAP should be on the care plan.					
	R23 had moderate	S dated 10/5/16, indicated cognitive impairment, used a eded extensive assistance				
	During observation on 11/1/16, at 12:46 p.m. R23 was hunched over and leaning to the right in her standard wheelchair.					
	was seated in her voutside her room. Very the right side of her shoulder pressed uninutes, her head to she appeared to be assisted into the direction.	on 11/1/16, at 4:59 p.m. R23 wheelchair in the hallway right While seated, R23 leaned to wheelchair with her right p against arm rest. After a few fell forward and to the right as a sleep. At 5:32 p.m. R23 was ning room. Staff did not n R23 prior to dinner.				
	p.m. to 6:12 p.m. R over and leaning to R23's head was ha touched the armres attempts were mad	rvation on 11/1/16, from 5:38 23 was observed hunched the right in her wheelchair. nging down so far it almost of the wheelchair. Staff e to encourage R23 to eat her o attempts were made to				
	was seated in a diff	on 11/2/16, at 7:18 a.m. R23 erent standard wheelchair by In this wheelchair, R23				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE	FALLS CARE CENTER	₹	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	continued to be hur forward with her he no longer leaning to was assisted into the reposition R23 were R23's care plan datassistance with whe plan did not contain positioning nor did intervene. During interview on stated R23 had recommended but was not LPN-E stated R23 was tired, and staff her bed or recliner. standard wheelchafor positioning. During interview on occupational therapposition in the wheel hunched over most wheelchair seemed armrests were a litt resident is more "sl not able to hold the a referral to therapy OT-A was unaware assessed by therapy During interview on assistant (NA)-G st after meals and whistated she tried to recliner or by placing or containing the placing or containing the place of the place o	nched over and leaning ead hanging down. She was of the right. At 8:05 a.m. R23 he dining room. No attempts to be made by staff. Ited 1/31/16, indicated needing eelchair mobility. R23's care interventions related to it direct staff on how to 11/2/16, at 7:44 a.m. LPN-E eived a new wheelchair that bot aware of who brought it in. Itended to lean more when she should offer repositioning to LPN-E was unsure if R23's in had been sized or assessed in 11/2/16, at 9:07 a.m. Dist (OT)-A observed R23's elchair and stated R23 sat often. OT-A stated the current I a bit big" for R23 and the le high. OT-A stated when a oppy" in the wheelchair or is mselves up, staff should make y to assess the wheelchair. If R23's wheelchair had been	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00382	B. WING		11/0	3/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	1200 FIRS	DRESS, CITY, S ST AVENUE N ALLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	During interview on stated she would as R23 was leaning in she would roll up a R23's wheelchair a should have intervence positioning. During interview 11, therapist (PT)-A states assess wheelchair they were appropriated R23's currer wide and therapy have reasonable.	11/3/16, at 7:46 a.m. NA-H sk R23 to "sit up more" when her wheelchair. NA-H stated small pillow or blanket in not thought the care plan entions the staff could do for /3/16, at 8:03 a.m. physical sted therapy would attempt to on admissions to make sure ate and sized correctly. PT-A at wheelchair seemed a little ad not been consulted to her stated it was not routine	2 830			
	was not aware of R wheelchair, further R23's wheelchair up appropriate, and did RN-A stated R23 to posture and expect she was uncomfort further stated the enursing assistants to leaning more in the stated the positioning R23's care plan becommon sense." During interview on stated wheelchairs and if residents were positioning issues in therapy to assess to were expected to residents.	11/3/16, at 1:38 p.m. RN-A 23 receiving a new stating she had assessed pon admission, felt it was d not need to be re-assessed. Inded to have a bent over ed staff to reposition R23 if able in the wheelchair. RN-A expectation would be for the conotify the nurses if R23 was wheelchair; however, RN-A and expectations were not on cause "it was a given, just 11/3/16, at 4:16 p.m. the DON were assessed as needed re leaning or having the would be an indication for hem. The DON stated staff exposition residents and assess the DON further stated she				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	` ′co		DATE SURVEY COMPLETED	
			A. BUILDING:				
		00382	B. WING		11/0	3/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
LITTLE F	FALLS CARE CENTER	₹	ST AVENUE I ALLS, MN 50	NORTHEAST 6345			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 24	2 830				
	would expect positi the care plans.	oning interventions to be on					
	Equipment, undated provide equipment highest most practic policy also directed	cled, Adaptive and Positioning d, directed the facility to to "achieve their [residents] cable level of function." The nursing to make referrals to ing and adaptive equipment					
	The director of nurse revise as necessary regarding CPAP us wheelchair position training for all approand procedures. The assurance committee the revise of the committee of the	THOD FOR CORRECTION: sing (DON) could review and y the policies and procedures age and orders as well as ing. The DON could provide opriate staff on these policies he quality assessment and ee could do random audits of ensure compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one					
2 895	MN Rule 4658.0529 Motion	5 Subp. 2.B Rehab - Range of	2 895			12/13/16	
	that is directed towa through positioning implemented and n comprehensive res of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which					
		h a limited range of motion e treatment and services to					

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Minneso	<u>ta Department of He</u>	alth				
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00382	B. WING		11/0	3/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER		T AVENUE I	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 25	2 895			
	increase range of n decrease in range of	notion and to prevent further of motion.				
	by: Based on observati review, the facility for range of motion (RG recommended for 1 on a restorative RC Findings Include: R23's quarterly Min 10/5/16, identified Fimpairment and no both upper and low A facility document Module, dated 1/12 lower extremity flex initial ROM assessor A General Nurse's Contained a Restora R23 participated in ROM six times were Osteoporosis and purchase of the program (Runder the program.	of 1 residents (R23) reviewed M program. imum Data Set (MDS) dated R23 had moderate cognitive functional limitation in ROM in er extremities. entitled Physical Therapy (PT) /16, indicated R23 had a right ion limitation noted during the ment. Observation, dated 10/5/16, ative Assessment indicating upper and lower extremity kly, related to diagnosis of revious Left Hip Fracture. d facility nursing assistant ied R23 was on a restorative NP) but did not list ROM		LFHS ensures each resident is givappropriate treatment and services maintain or improve his or her abil R#23 was referred to Physical ther 11-2-16 for ambulation assessment A restorative ambulation program developed and entered on the care and NAR group sheet. All residents on restorative ambulation program and the potential to be affected by deficient practice in this area. All NAR and Nursing staff were edd on R23 is ambulation program and documentation of restorative ambulation programs. Random observational audits will be completed to ensure that ambulation programs are being implemented. designee will conduct random aud minimum of 3 audits per week for weeks, then 2 audits/week x2 wee once weekly for 2 weeks and mon thereafter. Audit results will be brought to the	s to ities. rapy on ont. was e plan ation y a ucated d ulation DON or its. A 2 ks, then thly	
	under the program. R23's care plan dat needing assistance	ed 1/31/16, indicated R23 with mobility. It did not identify restorative program or		thereafter.	·	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	{	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 26	2 895			
	nursing assistant (Nevening cares beform her wheelchai were performed being During observation was seated in her with station. R23's morn performed. No ROM During interview on practical nurse (LPI ROM services from morning with morning with morning and received Final During interview on assistant (NA)-G statherapy room and a groups after breakfing.	11/2/16, at 7:44 a.m. licensed N)-E stated R23 received the nursing assistants in the ng cares. LPN-E was unsure if				
	During interview on physical therapist (I therapy when she whad been discharge recommendation for ROM. PT-A was un which ROM was reto find the original refurther stated no RO room. During observation performed ROM with a physical results of the physical results of the performed recompliance of the physical results of the physical recompliance of the physical recompliance of the physical results of the physical recompliance of the physical recompliance of the physical results of th	or upper and lower extremity sure of the frequency with commended and was unable ecommendations. PT-A DM was done in the therapy on 11/3/16, at 8:03 a.m. PT-A th R23 while sitting in her rated R23 did not have a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUIL DING.	MPLETED
A. BUILDING:	
00382 B. WING 1	/03/2016
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 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Comparison of the provider's plan of correction prefix (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
During interview on 11/3/16, at 7:46 a.m. NA-H stated the facility had two restorative assistants who were trained to perform ROM. When asked who completed ROM services if the restorative assistants were not in the facility, NA-H replied, "nobody, I don't think." During interview on 11/3/16, at 8:59 a.m. NA-F stated the nursing assistants were responsible for completing ROM if the restorative assistants were not available, however, NA-F thought ROM was not being completed due to staffing issues. NA-F further stated the facility used to set aside the afternoons for restorative assistants to complete ROM. Now the restorative assistants would try to get ROM in by setting up group activities. During interview on 11/3/16, at 2:05 p.m. NA-E stated the restorative assistants the do complete ROM seven days a week. NA-E stated the way staffing was, she worked more as a nursing assistant than in the restorative role. NA-E further stated when working in the restorative role she would be pulled onto the floor to do nursing cares. During interview on 11/3/16, at 1:38 p.m. registered nurse (RN)-A stated R23 was to receive ROM once a day, six days a week. RN-A stated the restorative assistants were responsible for completing ROM with the residents, however, the facility had struggled with staffing and did not always have restorative staff. On those days, the nursing assistant responsible for "Group C" were also responsible for ROM as "Group C" did not have a nursing assistant. RN-A further stated the facility	

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AND DIANICE CODDECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			711 2012211101			
		00382	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	₹	ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 28	2 895			
	acknowledged no o	ne evaluated if the groups receiving ROM.				
	stated the daily resi not getting done co staffing. RN-C furth	11/3/16, at 3:55 p.m. RN-C torative ROM programs were nsistently as ordered due to ter stated the restorative staff at role onto the floor to res.				
	During interview on 11/3/16, at 4:16 p.m. the DON stated the facility had three trained restorative assistants. If restorative staff are not available, the facility would attempt to find someone to cover and would move forward from there. The DON stated she would expect a restorative ROM program to be on the care plan.					
	2/1/16 to 11/3/16, s had received. It ide 2 days in February, days in July, fifteen September, and se indicated R23 had i	entitled, Therapy Audit, from howed the ROM services R23 ntified R23 had received ROM six days in June, twenty one days in August, twelve days in ven days in October. It not received any ROM in y and had not received ROM				
	11/8/15, directed re to be conducted da	eled Range of Motion, reviewed storative ROM programs were ily, on a one to one basis, and re to be performed in the				
	Restorative Nursing	ility document entitled, g Program (containing therapy was requested but not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. Bolesina.			
		00382	B. WING		11/0	3/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LITTLE F	ALLS CARE CENTER	₹	ALLS, MN 5	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 895	of Nursing or desig in-service to address receiving appropria range of motion lim appropriate treatment provided by the star monitoring program to assure an on-going program for resider	of Correction: The Director nee could schedule an as the importance of residents te treatment and services for itations. An assessment and ent intervention plan could be ff for these residents. An acould be established in ordering effective rehabilitative ints with range of motion.	2 895			
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing services that: A. a resident who without pressure sores unlessure sores un so	ent is not met as evidenced	2 900			12/13/16
	Based on observati	ion, interview and document ailed to provide necessary		Based on the resident s compreh skin assessment, LHFS ensures a		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		00382	B. WING		11/03/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	13,00,00
LITTLE F	FALLS CARE CENTER	2	ST AVENUE ALLS, MN 5	NORTHEAST 6345	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
2 900	healing of pressure for 1 of 3 residents ulcers who was not relief to the heel, ar infection control ted wound cares. Findings include: R2's Face Sheet idensified on 9/30/16, wanemia, weakness, disorder. The admission Min 10/7/16, identified Fulcers, had one Staunstageable pressureducing device for was on a turning ar The 14-day schedu 10/12/16, identified ulcers, had one staunstageable pressult also identified prechair and bed, and repositioning program During observation was lying in bed on were noted to be difloated (lifted off mathematics).	services to promote the ulcers and prevent infection (R2) reviewed for pressure observed to have pressure observed to have pressure and buttocks, and improper chique was provided during entified admission to the with diagnosis including and major depressive imum Data Set (MDS) dated R2 was at risk of pressure ulcer, had a pressure the chair and bed, and R2 and repositioning program. Iled assessment MDS dated R2 was at risk of pressure ge 2 pressure ulcer and one ure ulcer, and none worsening. It is sure reducing device for the R2 was on a turning and am. on 11/2/16, at 7:06 a.m. R2 her right side. Both heels rectly on the mattress, not attress to relieve pressure). on 11/2/16, at 7:39 a.m. the (DON) and registered nurse	2 900	resident with a pressure ulcer recencessary treatment and services promote healing and prevent new from developing. R#2 s care plan and NAR group were reviewed and revised prn to current plan of care for buttock ulcheel ulcer and Therapy to assess pressure relieving footwear. All residents with current pressure are at risk for a deficient practice is area. NAR staff were re-educated on Ricare plan, including the turning an repositioning program pertaining the protection (and the need to report nurse if the resident is refusing he protection). Nursing staff were re-educated or infection control techniques during dressing changes. DON or designee will conduct ran observational audits of residents wheel ulcer or at high risk of heel breakdown identified to require he protection. A minimum of 3 audits week for 2 weeks, then 2 audits/wweeks, then once weekly for 2 we then monthly thereafter. DON or designee will conduct ran observational audits of dressing conduct ran observational audits of dre	to ulcers sheets reflect cer and for sulcers n this #2 s d o heel to the el d dom with a sel s per seek x 2 eks, dom
	During observation director of nursing ((RN)-C entered R2 changes to the pres	on 11/2/16, at 7:39 a.m. the		DON or designee will conduct ran	hanges

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00382	B. WING		11/0	3/2016
	PROVIDER OR SUPPLIER	1200 FIRS		STATE, ZIP CODE NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	gloves, removed the buttock, and donne performing hand hy indicated being una and identified the wunstageable. RN-C Sea Cleans (wound gloves, RN-C place wound. At this time incontinent pad fast up. RN-C then procovered R2's torso, from the left heel. as unstageable. RI were not floated in sprayed on the wou without performing dressing was place were then removed a pillow beneath R2 the bed, then lower remote. At this time and washed her ha On 11/3/16, at 8:54 began. R2 was obsin the dining room, was observed in opback half of the slip heel, resting directly half off of the foot removed unchange remained in the act director (AD) assist offer to adjust the leassisted R2 out of the simple of the suit of the sign of the action observed unchanger remained in the act director (AD) assist offer to adjust the leassisted R2 out of the sign of the sign of the sign of the action observed unchanger remained in the act director (AD) assist offer to adjust the leassisted R2 out of the sign	e old dressing from the d clean gloves, without rgiene. At this time, RN-C able to see the wound base, round on the buttock as then sprayed the area with d cleanser). With the same of the new dressing on the et, the gloves were removed, tened, and pants pulled back ceeded to don clean gloves, and removed the dressing This wound was also identified N-C also verified R2's heels bed. The Sea Cleans was and, and gloves were changed, hand hygiene. A clean d on the wound. The gloves and RN-C assisted to place 2's legs to float the heels off ed the bed with the attached e, RN-C went to the bathroom	2 900	Audit results will be brought to the committee for review and further recommendation.	QAPI	

Minnesota Department of Health

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Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00382	B. WING		11/0	3/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	1200 FIRS		STATE, ZIP CODE NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	bathroom, and NA-Continuous observations and 24 minut wheelchair, with he resting on the foot mot offer to reposition independent of the resting on the foot of the resting on the foot of the reposition independent of the restinguish in the restinguish in the restinguish independent of th	F entered to assist. ation ended at this time. For 2 tes, R2 remained in her refoot observed with the heel rest. During this time, staff did on and R2 was not observed endently. ort For Selected Conditions 16 through 11/1/16, identified to a pressure ulcer on the state of wound. sue e age on ting mattress ting cushion for wheelchair de in bed and in recliner arance of wound.	2 900			

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Minnesota Department of Health

					(X3) DATE COMP	SURVEY LETED
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
LITTLE F	FALLS CARE CENTER	3		NORTHEAST		
0(0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	ALLS, MN 5		ONI	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 33	2 900			
	pressure reducing	or relieving device(s) in place e bed surface and chair sue e drainage ed white				
	have had a change is determined that of chair was changed washed and returning Family felt resident replaced cushion with doay to a pressure continues to be replaced to be replaced. Deterioration noted stage. Slough and					

Minnesota Department of Health

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Minnesota Department of Health

AND DUAN OF CODDECTION DEPT DESCRIPTION AND DE			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE	FALLS CARE CENTER		ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Record (ETAR) Reidentified an order of Foam dressing Q3c [as needed] to upper day every 3 days distructions: clean meplex. Notify RN initialed this as beir ordered. The order to coccyx/low back Document Dressing Characteristics - District Wound, Special Instally. document chaily. Skin Condition Rep dated 9/30/16 throuf ollowing related to heel: 9/30/16 unstageable 2.7 x 4.0 wound base not vising 100% eschar tissue surrounding tissue margins are irreguld drainage thick, scapresent on admissinoted to have place bed, noted as dated turn and repositionis sheep skin booties float heels when layer and the stage of the skin booties float heels when layer and the skin boot	port for October, 2016, dated 10/6/16, "Light exudate: days [every three days] or prner rt [right] buttock 1 time per uring Evening, Special and place appropriate size of changes in wound." Staffing completed every 3 days as changed to, "dressing change 1 time per day during Day, g Change: Document rainage & Odor Skin and structions: Meplex change naracteristics, drainage. Notify s and symptoms] of infection." Fort For Selected Conditions and symptoms of infection." Fort For Selected Conditions and symptoms of infection."	2 900			

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Minneso	ta Department of He	ealth			1011117111110121	_
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.110 1 27.11	or connection	BERTH TO/THORNOLLER.	A. BUILDING:		JOHN LETES	
		00382	B. WING		11/03/2016	
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	ALLS CARE CENTER	2	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		
				DEFICIENCY)		
2 900	Continued From pa	ge 35	2 900			
	10/4/16					
	10/4/16 2.7 x 4.0 (only measurements available from RN-C - no note)					
	10/11/16					
	10/11/16 2.6 x 4.0					
		s available from RN-C - no				
	10/19/16					
	2.6 x 4.0 (only measurement note)	s available from RN-C - no				
	10/19/16					
	wound base not vis	ible				
	100% eschar tissue 2.6 x 4.0					
	10/21/16					
	drainage thin, scan	t, brownish red				
	10/25/16					
	wound base not vis					
	slough and/or esch 2.6 x 4.0	ar covered				
	no drainage appare	ent				
	covered with black					
	11/1/16					
	2.4 x 3.7					
	(only measurement note)	s available from RN-C - no				
		ort for October, 2016, identified 5/16, "Moderate/Heavy				

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Exudate: Foam dressing QD [every day] to left heel 1 time per day during Evening, Special

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00382	B. WING		11/0	3/2016
	PROVIDER OR SUPPLIER	1200 FIRS		STATE, ZIP CODE NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	Instructions: Clean notify RN if change this as being completed date were to provide external	wound and dress. Please in wound site." Staff initialed eted daily. The same order mber 2016, and was signed as tilly. d 10/31/16, identified staff ensive assistance as follows: rning and repositioning when ke resident to the toilet. staff for ambulation e ulcer to coccyx / low back, of an air mattress and to turn y two to three hours. ning in wheelchair	2 900			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00382	B. WING		11/0	2/2016
NAME OF				OTATE 7/ID OODE	11/0	3/2016
	PROVIDER OR SUPPLIER	1200 FIRS		STATE, ZIP CODE NORTHEAST		
LITTLE F	FALLS CARE CENTER	₹	ALLS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 37	2 900			
	form dated 9/30/16 therapy following a a pressure sore on	, indicated R2 was referred to hospital stay. It also identified the left heel. No mention was e ulcer on the mid right buttock.				
	documentation date failed to identify a p	onal and physical therapy ed 9/30/06 through 11/3/16, bressure ulcer on the mid right est for evaluation of an				
	registered nurse (Runstageable pressuloss in which the baslough) to the left hpressure ulcer (par presenting as a shared	10/31/16, at 12:31 p.m. IN)-C stated R2 had an ure ulcer (full thickness tissue ase of the ulcer is covered by eel as well as a Stage 2 tial thickness loss of dermis allow open ulcer with a red thout slough) to the upper right				
	assistant (NA)-A de issues with R2. WI R2 in the morning, from beneath her k replaced. NA-A ver	11/2/16, at 7:24 a.m. nursing enied being aware of any skin nen she helped to reposition the pillow had been kicked out nees, and R2 did not want it rified R2's heels were resting ress at this time, not being				
	stated staff would be the dressing on the contaminated, or lo to notify RN-A with if there were a char denied being aware and denied being in pressure ulcer prior	11/2/16, at 8:54 a.m. RN-C be expected to notify nursing if buttock is saturated, ose. Staff are also expected any changes on the floor, and age in skin condition. RN-C expected of the frequent incontinence, aformed of the change in the red to doing wound rounds on sion, the dressing change was				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE	FALLS CARE CENTER	3	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	ordered every three changed to daily. E changed more freq stated R2 has a nu when in bed. RN-C floated that morning wound care, and w happens. RN-C stareport any changes the RNs. During interview on member (F)-C state cushion were lost, a located, but the cushion were fodays. Tof days later. F-C of for two to three day about three to five on 10/16 and found remained missing, black and yellow custing the care conthat the cushion was complained that he 10/24/16, RN-A procushion. On 11/1/1 currently being use During interview on stated R2 has a drebuttock. It was bein and was changed the would look if R2 haverify it with a name the cushion should	e days, and on 11/1/16, it was Both orders were to be uently as needed also. RN-C rsing order to float the heels c verified R2's heels were not g when she entered to do as not aware of how often this ated staff are expected to or non-compliance to one of 11/2/16, at 10:25 a.m. family ed initially the chair and the and then the chair was shion remained missing for a the pad was located a number stated the chair was missing s, and the pad was missing days. 11/3/16, at 1:00 p.m. F-D s, the wheelchair was missing and R2 was provided a vinylushion to use. On 10/19/16, at missing and R2 had r bottom was hurting. On wided R2 with a different 6, RN-C provided the cushion	2 900			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00382	B. WING		11/0	3/2016
	PROVIDER OR SUPPLIER FALLS CARE CENTER	1200 FIRS	, ,	STATE, ZIP CODE NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	the chair or cushion stated R2 is to be to two to three hours. black slippers that sto the slipper, and is footwear R2 is to be During interview on stated R2 is current R2 was referred for believed therapy alve the wheelchair at any padmission resident first 24 hours, and applied as needed, RN-A stated she wo there were a chang reported to the RN. that there was a de previously a Stage RN-A added, "[R2] stated she would exnoncompliance or control in the state of the st	n had been missing. She urned and repositioned every NA-F stated R2 has her own she wears. There is no back is not aware of any special	2 900			
	verified the wound to a Stage 2 to unstage was increased from the nurse practition to continue current aware of a change discovered the charmounds, RN-C place wheelchair. RN-C stage of the stage of th	11/3/16, at 1:38 p.m. RN-C to the upper buttock went from leable. The dressing change in every three days to daily. The many mer was notified, and indicated orders, and verified being to the wound. When she had on 11/1/16, during wound and the correct cushion on the stated she believed the root was in the wound was the				
	incorrect cushion be	ge in the wound was the eing used. She denied fferent cushion being used,				

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Minnesota Department of Health

WIIIIII	na Department of Tie	alli				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00382	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	ALLO CADE CENTER	1200 FIRS	T AVENUE I	NORTHEAST		
LIIILE	FALLS CARE CENTER	LITTLE FA	ALLS, MN 50	6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 40	2 900			
	and would expect if her. RN-C stated with she found a black a adequate for pression this with a flatter cuidid not like the black indicating it made indicating it made indicating it made indicating it made in the cushion. R2 used to week. When she buthe cushion to what stated the change in avoidable, had the RN-C also stated shassess for a proper say for sure if this hunable to find any distance to change the schedule from ever change in the wound stated no assessment determine if this schedule from ever change in the wound stated no assessment for the wound stated for the wound stat	staff notice this, they inform when the cushion was missing, and yellow cushion that was ure ulcers. Family replaced shion from home, since they sk and yellow cushion, R2 sweat. However, they did ty they had changed the the thinner cushion for one secame aware, RN-C replaced to R2 is currently using. RN-C in the pressure ulcer was cushion not been changed. The assumed therapy would be cushion, but was not able to had been done for R2, and was documentation. RN-C also determined there was not turning and repositioning by two to three hours after the lad. However, RN-C also lent had been completed to hedule was still sufficient while hair. Related to the heel, leel should not be resting lest, and staff education was				
	stated RN-C is wou recommendations, required assessme was more appropria interventions than the certified. DON wou worsened going fro	herapy as she is wound ıld not acknowledge ulcer had m a Stage 2 to unstageable,				
	DON stated NAs we change in the cushi	seen it when R2 was admitted. ould report if they noted a ion, but added they are not y would know there is a				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET					
		00382	B. WING		11/0	3/2016
	PROVIDER OR SUPPLIER	1200 FIRS		STATE, ZIP CODE NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	cushion, but that is p.m. DON stated the cushion the family proverified there is no perificated the present, treat, and pulcer (s). It also insists with ulcers to the wear circulation by change review all current in remain appropriate. SUGGESTED MET director of nursing (the pressure ulcer perificated the importance of a implementing pressure ulcers to estaff to monitor that implemented. The cassurance committed the appropriate care	it. Further interview at 2:57 ere was a change due to the placed in the chair, and process in place to ensure the cushion was in place for sure ulcer. Skin Ulcer Protocol, updated dervices will be provided to monitor progress of all healing tructed staff to report all open ound nurse, improve ging position frequently, and terventions to ensure they THOD OF CORRECTION: The (DON) could review and revise protocol. In addition, the DON ation to the nursing staff on assessing pressure ulcers and sure reducing interventions. Welop a system for the nursing a interventions are quality assessment and ee could do random audits of ensure residents are receiving	2 900			
2 915		5 Subp. 6 A Rehab - ADLs	2 915			12/13/16
	comprehensive res	of daily living. Based on the ident assessment, a nursing that: given the appropriate				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	_ETED
		00382	B. WING		11/0	3/2016
NAME OF		OTDEET AD	DECC OITY (717. 719.00P.		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LITTLE F	ALLS CARE CENTER	₹		NORTHEAST		
		LITTLE FA	ALLS, MN 5	6345		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
		,		DEFICIENCY)		
2 915	Continued From no	go 42	2 915			
2 913	Continued From pa	ge 42	2 913			
		vices to maintain or improve				
	abilities in activities of daily living unless					
	deterioration is a normal or characteristic part of					
	the resident's condition. For purposes of this					
	part, activities of daily living includes the					
	resident's ability to:					
	(1) bathe, dress, and groom;					
	(2) transfer and ambulate;(3) use the toilet;(4) eat; and(5) use speech, language, or other					
	functional communication systems; and					
		ent is not met as evidenced				
	by:			D# 00	-1	
		on, interview, and document		R# 23 was referred to Occupation		
		ailed to reassess and		Therapy for ROM program on 11-2 restorative range of motion progra		
		nent an ambulation program (R23) reviewed for ambulation		developed and entered on the care		
	with a restorative p	,		and NAR sheet.	e piari	
	with a restorative pr	ogram.		and WAIT Sheet.		
	Findings Include:			Restorative and NAR staff were ed	ducated	
				on R#24 s ROM program.		
	R23's quarterly Min	imum Data Set (MDS) dated		F - 2		
		R23 had moderate cognitive		All residents with restorative ROM		
		eded extensive assistance of		programs have the potential to be		
	one person to walk	both in her room and outside.		impacted by a deficient practice as	s it	
				relates to range of motion services	S.	
		d physician orders, dated				
		23 was to walk to meals three		DON/designee will conduct randor		
	times a day.			observational audits to ensure that		
	A	d 6 - 49		programs are being completed an		
		ed facility nursing assistant		documented. A minimum of 2 aud		
		ed R23 was on a restorative		week for 2 weeks, then 2 x week x		
		INP) and directed staff to walk		weeks, then once weekly for 2 weeks	eks and	
	R23 to meals.			monthly thereafter.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (DENTIFICATION NUMBER: A. BUILDING:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00382	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	₹	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From page 43		2 915			
	staff to walk R23 in ambulation. The Facility Treatm	plan dated 1/31/16, directed order to prevent a decline in ent Sheet Records, for 8/16,		Audit results will be brought to the committee for review and further recommendation.	QAPI	
	to meals 3 times pe	ntained the order to walk R23 or day. The Treatment Sheets nursing staff to show curred.				
	Detail Report, from total walking/restora received. It identifie restorative ambulat days in July, twenty days in September,	entitled, Walking Therapy 2/1/16 to 7/1/17, showed the ative care services R23 had d R23 had received ion one day in June, fourteen two days in August, fourteen and seven days in October. It not received restorative ovember.				
	was seated in her w (NA)-D was observed R23's wheelchair as	on 11/1/16, at 5:32 p.m. R23 wheelchair. Nursing assistant ed to put foot pedals onto nd proceeded to push R23 to supper. No attempt or offer with R23.				
	stated the nursing a R23 in her wheelch R23 did not walk as stated the staff did	11/2/16, at 8:00 p.m. NA-D assistants typically pushed air to meals and further stated amuch as she used to. NA-D not walk with R23 that night out of it" and the unit was				
	was being pushed i	on 11/2/16, at 8:05 a.m. R23 n her wheelchair from the the dining room for breakfast.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE I	FALLS CARE CENTER	₹	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 915	During interview on practical nurse (LP restorative program due to knee pain. L nursing assistants with R23, however, throughout the day, was documented oso R23 could be proposed by the depth of the d	a 11/2/16, at 7:44 a.m. licensed N)-E stated R23 was on a but did not walk that morning PN-E further stated the were responsible for walking due to the "hustle and bustle," was not sure the walking r that they informed the nurse e-medicated before walks. on 11/2/16, at 11:52 p.m. R23 ated in her wheelchair. R23 ated from the bed into the G and NA-I. R23 was again shed in her wheelchair to lunch. In 11/2/16, at 12:02 p.m. NA-G used to walk to lunch and shard for R23 to even stand G stated R23 does not ever was not aware R23 was on a tion program. In 11/2/16, at 12:07 p.m. PT)-A stated R23 had received was admitted to the facility and end with therapy for a restorative ambulation and the R23's goal was to ambulate at a time. PT-A further stated residents quarterly which cline in mobility, however, was quarterly screenings or therapy	2 915			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER D0382 B. WING		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST				71. BOILBING.			
LITTLE FALLS CARE CENTER 1200 FIRST AVENUE NORTHEAST			00382	B. WING		11/0	3/2016
LITTLE FALLS CARE CENTER	NAME OF	PROVIDER OR SUPPLIER					
	LITTLE	FALLS CARE CENTER	3				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETE DATE
Continued From page 45 dining room, but thought staff could attempt to walk her once R23 was closer to the dining room. During observation on 11/3/16, at 8:03 a.m. PT-A ambulated R23 in the facility hallway and stated R23 did not have a functional decline in ambulation. However, PT-A stated a lesser goal of ambulating once a day may be more appropriate for R23, since switching rooms, the distance between her room and the dining room was longer. During interview on 11/3/16, at 1:38 p.m. registered nurse (RN)-A stated the nursing assistants were responsible for walking with R23 and thought R23's restorative ambulation program was being done as she often saw R23 ambulate to the bathroom and in her room. RN-A further stated LPN's were responsible for monitoring the completion of the ambulation program. RN-A thought the ambulation documentation was not representative of R23's walking and staff needed education on charting. RN-A stated R23 rarely refused walking, especially with encouragement. RN-A stated the new distance between R23 room and the dining room was "under review" but had not been fully reassessed. During interview on 11/3/16, at 3:55 p.m. RN-C stated restorative programs were not getting done consistently as ordered and were currently re-doing the ambulation program facility wide. During interview on 11/3/16, at 4:16 p.m. the director of nursing stated the inconsistency in R23 s ambulation program was due to documentation errors by the nursing assistants.	2 915	dining room, but the walk her once R23 During observation ambulated R23 in the R23 did not have a ambulation. However, of ambulating once appropriate for R23 distance between howas longer. During interview on registered nurse (Rassistants were researed thought R23's approgram was being ambulate to the bat further stated LPN's monitoring the comprogram. RN-A thought restriction was walking and staffing RN-A stated R23 respecially with encounew distance between was "under receassessed. During interview on stated restorative program the ambulation program interview on director of nursing sreading the ambulation program interview on director of nursing sreading interview on director of nursing	bught staff could attempt to was closer to the dining room. on 11/3/16, at 8:03 a.m. PT-A he facility hallway and stated functional decline in er, PT-A stated a lesser goal a day may be more 8, since switching rooms, the her room and the dining room and the dining room and the dining room stated the nursing reponsible for walking with R23 restorative ambulation done as she often saw R23 throom and in her room. RN-A is were responsible for pletion of the ambulation and representative of R23's rededed education on charting. The arely refused walking, buragement. RN-A stated the reen R23 room and the dining review" but had not been fully a 11/3/16, at 3:55 p.m. RN-C rograms were not getting done are and were currently refused and were currently retailed the inconsistency in rogram was due to				

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	IT OF DEFICIENCIES OF CORRECTION					
		00382	B. WING		11/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	FALLS CARE CENTER	₹	ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	ge 46	2 915			
	was the responsibil Coordinator (a regis restorative goals for aspects of the restoration	riewed 8/23/15, indicated it ity of the Restorative stered nurse) to establish r residents, monitors all brative program, and oversees of nursing/restorative				
	Restorative Nursing	ility document entitled, g Program (containing therapy was requested but not				
	The director of nurs review and/or revise residents identified restorative program inservice to staff regresidents; and deve	THOD OF CORRECTION: sing (DON) or designee could e policies and procedures, for as benefiting from an a; provide education and garding care of those identified elop, or revise a monitoring e, and ensure on-going				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 930	MN Rule 4658.0525 Nasogastric, Gastro	5 Subp. 7 B. Rehab - ostomy tubes	2 930			12/13/16
	and feeding syringes. Based of assessment, a nurs B. a resident w gastrostomy tube of appropriate treatment	ric tubes, gastrostomy tubes, in the comprehensive resident sing home must ensure that: who is fed by a nasogastric or in feeding syringe receives the cent and services to prevent hia, diarrhea, vomiting,				

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Minnesota Department of Health							
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE : COMPI		
		00382	B. WING		11/0:	3/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
TITLE FALLS CARE CENTER		T AVENUE ALLS, MN 5	NORTHEAST 6345				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 930	Continued From pa	ge 47	2 930				
		olic abnormalities, and lcers and to restore, if eding function.					
	by: Based on observation review, the facility for the gastrostomy tubes stomach for feeding an eternal feeding a residents (R40) who will be feeding Jev hour times 24 hours indicated he was to G-tube with 30 cubes before and after me R40's care plan data to check placement medications via the orders. During observation licensed practical nuchange bottle of Je LPN-A took a 60 congraduate container tab water, opened for the syringe infattempted to flush to met resistance. LPI placement by aspiraremoved 60 cc syristated she needed	der dated 10/4/16, directed ity 1.2 at 65 milliliters (ml) per s. R40's medication orders receive his medications via ic centimeter (cc) flushes		LFHS ensures a resident with a Greceives the appropriate treatment services to prevent complications possible, to restore normal eating R#40- Nursing staff caring for R#4 re-educated on the process for chaplacement of the G-tube. All residents with G-tubes have the potential to be affected by a practideficient in this area. All licensed staff were re-educated checking placement of a G-tube a directed by the facility G-tube polic MD order's. DON or designee will complete rail observational audits of G-tube car ensure appropriate checking of pla of the tube. A minimum of 2 audits week for 2 weeks, then 2 audits/w weeks, then once weekly for 2 weethen monthly thereafter. Audit results will be brought to the committee for review and further recommendation.	t and and if skills. 40 was ecking ecce 4 on secy and endom ecto accement sece per eek x2 eks and		

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00382	B. WING		11/0	3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE FALLS CARE CENTER			ST AVENUE I ALLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 930	narrow tip from R40 with 60 cc of water and flushed G-tube G-tube placement ILPN-A connected r G-tube port and state confirmed R40 had check for G-tube pl starting infusion of During observation prepared medication cup to administer the entered R40's room stethoscope around and donned gloves water into the medimedication prior to off feeding pump, oplaced the 60 cc's LPN-B then poured syringe to flush via LPN-B was unable water after several LPN-B did not check aspiration or auscul walkie talkie and as coke to R40's room nurse (RN)-A enteressist LPN-B with frepositioning R40 at tubing. RN-A did not by aspiration or auscul different 60 cc syring able to flush G-tube aspiration or auscul During interview on stated at that time stated at that time stated at that times.	O's closet, filled the syringe r, and opened the G-tube port e. LPN-A did not check for oy aspiration or auscultation. New tube feeding to R40's arted the feeding pump. LPN-A is a G-tube and she did not lacement prior to flush or Jevity. On 11/01/16, 7:37 p.m. LPN-B on and placed medication in a nrough R40's G-tube and in. LPN-B who had a did her neck, washed her hands in, then poured 30 cc's of tapication cup to dissolve the administration. LPN-B turned disconnected the tubing, and syringe into the G-tube port. If 60 cc's of distilled water into gravity and met resistance, to administer the flush with attempts to manipulate tubing. It is for G-tube placement by lattation. LPN-B got on the sked the nurse to bring some in to flush G-tube. Registered ared room and attempted to lushing G-tube by and massaging the G-tube placement scultation. LPN-B used a lange with a narrow tip and was a and administer medication. It is considered to the considered red room and attempted to lushing G-tube by and massaging the G-tube and administer medication. It is considered to get the considered red room and attempted to lushing G-tube by and massaging the G-tube and administer medication. It is considered to get with a narrow tip and was a and administer medication. It is considered to get and administer medication. It is considered to get the considered to	2 930			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00382	B. WING		11/0	3/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	ALLS CARE CENTER	₹	T AVENUE I LLS, MN 50	NORTHEAST 6345		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 930	stated the G-tube n placement by aspira flushing, medication new feeding. RN-A policy dated 6/01/16 confirmed at that tir been checked for p meeting resistance. SUGGESTED MET The Director of Nur develop, review, an procedures to ensu are monitored for p feeding tube. The Director of Nur educate all appropriocedures. The Director of Nur develop monitoring compliance.	11/01/16, 8:20 p.m. RN-A eeded to be checked for ation or auscultation prior to administration, and starting confirmed enteral feeding 5, was current. RN-A me R40 G-tube should have lacement especially when	2 930			
21390	(21) days.	O Subp. 4 A-I Infection Control	21390			12/13/16
21330	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and	and procedures. The infection ust include policies and provide for the following: based on systematic data rosocomial infections in detection, investigation, and sof infectious diseases; diprecautions systems to mission of infectious agents;	21000			12/13/10

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S	
		00382	B. WING		11/01	2/2016
					11/0	3/2016
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LITTLE F	ALLS CARE CENTER	₹	LLS, MN 5	NORTHEAST 6345		
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po practices, including defined in part 4658 G. a system for H. a system for products which affe disinfectants, antise incontinence product I. methods for a current standards of This MN Requirement by: Based on observation review the facility fa hygiene was impler observed for wound failed to ensure app practices were follo who was in contact Findings include: R2 was observed of director of nursing ((RN)-C entered R2)	ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 8.0815; reviewing antibiotic use; review and evaluation of oct infection control, such as eptics, gloves, and cts; and maintaining awareness of of practice in infection control. ent is not met as evidenced on, interview and document ailed to ensure proper hand mented for 1 of 1 resident (R2) of care. In addition, the facility propriate infection control wed for 1 of 1 resident (R49)	21390	LFHS has established an Infectior Program designed to provide a sa sanitary and comfortable environm to help prevent the development a transmission of disease and infect R#2-Nursing staff providing wound for R#2 were re-educated on prophygiene (washing hands when chargloves) with wound care. R#49- The soiled laundry hamper placed inside the room and staff of for R#49 were re-educated on per	fe, nent and ind tion. d care er hand anging was caring	
	gloves, removed the buttock, and donne	left heel. RN-C donned e old dressing from the d clean gloves, without giene. RN-C then sprayed the		All residents have the potential to affected by a practice deficient in t	be	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00382	B. WING		11/0	3/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TITLE FALLS CARE CENTER		ALLS, MN 5	NORTHEAST 6345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From particles are a with Sea Clear the same gloves, Ron the wound. At the removed, incontine pulled back up. RN clean gloves (witho R2's torso, and remileft heel. The Sea wound, and gloves performing hand hyplaced on the wound removed, and RN-C beneath R2's legs to lowered the bed wittime, RN-C went to hands. During interview on stated she typically between each wour soiled gloves each hand hygiene was puthe entire process of the continuous control of the	age 51 ans (wound cleanser). With RN-C placed the new dressing his time, the gloves were ent pad fastened, and pants N-C then proceeded to don out washing hands), covered noved the dressing from the Cleans was sprayed on the were changed, without ygiene. A clean dressing was not. The gloves were then C assisted to place a pillow to float the heels off the bed, the the attached remote. At this of the bathroom and washed her and, but not after removing the time. RN-C also verified no performed until finished with during the observation. 11/3/16, at 2:10 p.m. DON bected to perform hand hygiene lange. Dressing Change - Clean,	TAG 21390		vational times 2 ks, then thly vational iques ss/week weeks	DATE
	plastic bag at foot of a Remove gloves at a Wash hands. Put wound with prescribed to Apply prescribed to the state of the	of bed nd discard t on clean gloves. Cleanse bed solution if ordered. medications as ordered and secure with tape				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
				44.6	2:22.42
	00382	b. Willia		11/0	3/2016
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LITTLE FALLS CARE CENTER			NORTHEAST		
	T	ALLS, MN 56			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21390 Continued From page	ge 52	21390			
R49 had a clostridium infection, and the fact appropriate infection. The Center for Disease for health care facility when caring for reside infection: Isolate pattered immediately. Wear of treating patients with visits. Hand sanitized although hand wash not be sufficient along gloves. Clean room daily basis while treat and upon patient disconsisted in Supplement cleaning bleach or another Eldisinfectant. R49's diagnosis list is clostridium difficile (a can cause swelling a intestine, or colon. Toolitis, can cause diacramps). Progress in tested positive for cleased posi	m difficile (C. difficile) cility did not implement a control precautions. ase Control (CDC) guidelines ties directed the following dents with a C. Difficile cients with C. difficile gloves and gowns when a C. difficile, even during short or does not kill C. difficile, and an	21390			

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-	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00000	B. WING		44/0	0/0046
		00382	B. WING		11/0	3/2016
NAME OF PROVIDER OR SUPPLIER STREET A		DRESS, CITY, S	STATE, ZIP CODE			
		1200 FIRS	T AVENUE I	NORTHEAST		
LITTLE F	FALLS CARE CENTER	₹	ALLS, MN 50			
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES			NI.	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
21390	Continued From pa	go 53	21390			
21000	Continued From pa	ge 55	21000			
	with soap and wate					
		on 11/02/16, at 1:23 p.m.				
		oist (OT)-A exited R49's room				
	and removed her po	otentially contaminated gown				
		and placed gown in dirty linen				
		9's room. OT-A stated R49				
	was on contact pred	cautions for C. difficile, and				
	needed to remove y	your mask, gloves, and wash				
	hands with soap an	d water prior to leaving R49's				
	room. OT-A further	stated the gown was removed				
	outside of R49's roo	om and placed in the hamper.				
	During observation	on 11/02/16, at 1:36 p.m.				
	licensed practical n	urse (LPN)-A put on a gown,				
	mask, and gloves p	prior to entering R49's room.				
	LPN-A entered R49	s room and approached R49				
	and explained she	was going to check for edema.				
	LPN-A lifted up R49	9's right pant leg, and placed				
	her gloved hand on	his leg, applying pressure to				
	leg. LPN-A did the s	same to left leg. LPN-A				
	removed mask and	gloves and discarded them in				
	the trash can in R49	9's room. LPN-A exited R49's				
	room, and removed	the potentially contaminated				
	gown outside of R4	9's room, and placed the				
		namper outside R49's room.				
		lown hallway to nursing station				
	where she entered	the bathroom, and washed				
		p and water. LPN-A was				
		ted at that time handwashing				
		R49's room prior to exiting				
	room.	1				
	During interview on	11/20/16, at 2:30 p.m. NA-A				
		d her mask and gloves in				
		ated she washed hands in				
	bathroom by nurse's					
		11/02/16, at 1:17 p.m. NA-B				
		solation for C. difficile, and				
		9's room you put on a mask,				
		When exiting R49's room the				
		re removed, and thrown in				
	i iliask allu gloves al	e removed, and unown in				

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trash can, hands are washed in room before

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00382	B. WING		11/0	3/2016
		00002			11/0	3/2010
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE FALLS CARE CENTER		1200 FIRS	T AVENUE I	NORTHEAST		
LIIILEF	ALLS CARE CENTER	LITTLE FA	ALLS, MN 50	6345		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
21390	Continued From pa	ge 54	21390			
	eviting and down is	s placed in dirty hamper				
		om. NA-B stated she washes				
		e hand sanitizer, instead of				
	soap and water price					
		11/03/2016, 11:02 a.m. the				
		stated her expectations for C.				
		nands should be washed with				
		ore leaving R49's room and				
		mper should be kept inside of				
	R49's room.					
	The facility policy 6.	.0 Infection Prevention and				
		ated 1/16, directed Contact				
		tituted for residents with				
		icile infection. Policy 6.14				
		ns-Transmission Based dated				
		e sure that an adequate supply				
		and paper towels are				
		oom during the isolation				
		gown and perform hand				
	hygiene before leav	ring the resident's				
	environment.					
	O	of Commentions. The				
	Suggested Method					
		signee could review policies				
		ensure, proper infection				
		ound care techniques and				
		s are followed. Facility staff				
		d and an auditing system				
	developed to ensur	e compliance.				
	Time Period for Co	rrection: Twenty one (21)				
		rrection. Twenty one (21)				
	days.					
04.005	MNID 4050 4404		04005			10/10/10
21665	IVIN Hule 4658.1400	O Physical Environment	21665			12/13/16
	A nuraina hama	ust provide a gofa place				
		ust provide a safe, clean,				
		able, and homelike physical				
		ng the resident to use				
	personal belonging	s to the extent possible.				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPL	
		00382	B. WING		11/03	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE F	ALLS CARE CENTER	₹		NORTHEAST		
			ALLS, MN 5	PROVIDER'S PLAN OF CORRECTION	NI NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 55	21665			
	by: Based on observati review, the facility for equipment for 2 or 2 wheelchair and foot Findings Include:	ent is not met as evidenced on, interview, and document ailed to maintain resident care 2 residents (R23, R33) whose t pad were is disrepair.		LFHS provides a safe, functional,s and comfortable environment for residents, staff and the public. R #23-new wheelchair armrests w obtained and placed on wheelchai	ere r.	
	R23's quarterly Minimum Data Set (MDS) dated 10/5/16, indicated R23 used a wheelchair for mobility.			R #33- the calf protector was removed and replaced. All residents that utilize wheelchair		
	presented with multi fabric of her left who extended length wis foam padding was	on 11/1/16, at 6:47 p.m. R23 tiple long cracks in the black eelchair armrest. The cracks se along the armrest and white visible through the cracks.		the potential to be affected by a depractice. All staff were re-educated on main resident equipment specifically wheelchairs and reporting any whe that is in disrepair.	eficient	
	assistant (NA)-E stacracks but should sto R23's armrests. Inot be able to be clustaff should have fill	a 11/1/16, at 7:10 p.m. nursing ated she was not aware of the staff should be paying attention NA-E stated the armrest would eaned well, and further stated, lled out a maintenance slip to could be fixed or to get R23 a		Maintenance director or designee conduct an audit of all resident wheelchairs, then will continue ran audits weekly with their environme checks.	dom ntal	
		dated 9/28/16, indicated R33 for mobility with functional lower extremities.		Audit results will be brought to the committee for review and further recommendation.	WAFI	
	presented with a blue 10 inches (in) by 17 while sitting in his was between R33's leg	on 10/31/16, at 1:58 p.m. R33 ue rectangular pad, measuring in, under his feet and ankles wheelchair. The pad, located rests, appeared to be torn on k tape covering the torn areas.				

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PRINTED: 12/02/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 00382 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS CARE CENTER LITTLE FALLS, MN 56345 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21665 Continued From page 56 21665 Upon further inspection on 11/3/16, at 10:51 a.m. the duck tape was wrapped completely around the bottom and back of the cushion while R33 rested his ankles on the tape. NA-F stated the pad had ripped and the duck tape was holding the pad together. NA-F further stated the pad was to ensure R33's legs would not catch between the foot pedals. She also stated R33 should not have his feet on the duck tape, someone should have noticed the tape, and filled out a maintenance slip to for it to be repaired.

During interview on 11/3/16, at 1:50 p.m. director of maintenance stated he had not received any repair requests for the wheelchair pads or armrests. The DOM stated staff should fill out maintenance slips for equipment in disrepair so it could be fixed.

During interview on 11/3/16, at 4:56 p.m. registered nurse (RN)-A stated she would expect staff to fill out a maintenance form for care equipment in disrepair so the equipment could be fixed.

An facility policy entitled, Maintenance Slip Policy, undated, instructing staff to fill out maintenance forms for repairs in order to maintain "equipment in a safe and operable manner."

SUGGESTED METHOD OF CORRECTION: The administrator, director of maintenance, or designee could update facility policies and procedures related to requesting and tracking for repairs of care equipment. Audits could also be completed to ensure resident care equipment is in good operating condition.

TIME PERIOD FOR CORRECTION: Twenty One

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PRINTED: 12/02/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING _ 00382 11/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS CARE CENTER LITTLE FALLS, MN 56345 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE (X4) ID PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 57 21665 21665 (21) days.

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