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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: XBVT

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

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial — 2. Recertification
3. Termination — 4. CHOW
5. Validation — 6. Complaint
7. On-Site Visit — 9. Other
8. Full Survey After Complaint

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

6. DATE OF SURVEY **02/18/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 40 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
Jennifer Bahr, HFE NE II — 02/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS
Posted 03/08/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**02/08/2016**
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245399
February 25, 2016

Ms. Amy Walker, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, Minnesota 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 January 31, 2016 the above facility is certified for or recommended for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 25, 2016

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

RE: Project Number S5399026

Dear Ms. Walker:

On January 13, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 30, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 18, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 30, 2015, effective January 31, 2016 and therefore remedies outlined in our letter to you dated January 13, 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.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
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Enclosure

cc: Licensing and Certification File

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 245399 Y1 | A. Building<br>B. Wing Y2 | 2/18/2016 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LITTLE FALLS CARE CENTER | 1200 FIRST AVENUE NORTHEAST<br>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).

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix F0279 | Correction | ID Prefix F0311 | Correction | ID Prefix F0314 | Correction |
| Reg. # 483.20(d), 483.20(k)(1) | Completed | Reg. # 483.25(a)(2) | Completed | Reg. # 483.25(c) | Completed |
| LSC | 01/31/2016 | LSC | 01/31/2016 | LSC | 01/31/2016 |
| ID Prefix F0323 | Correction | ID Prefix F0441 | Correction | ID Prefix F0465 | Correction |
| Reg. # 483.25(h) | Completed | Reg. # 483.65 | Completed | Reg. # 483.70(h) | Completed |
| LSC | 01/31/2016 | LSC | 01/31/2016 | LSC | 01/31/2016 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
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| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| | JS/KJ | 02/25/2016 | 35575 | 02/18/2016 |
| **REVIEWED BY CMS RO** ☐ | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |
| | | | | |

**FOLLOWUP TO SURVEY COMPLETED ON**
12/30/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: XBVT

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

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(L5) **LITTLE FALLS, MN** (L6) **56345**

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8. Full Survey After Complaint

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(L9) **01/01/2014**

6. DATE OF SURVEY **02/18/2016** (L34)

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**09/30**

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE — Date :
Jennifer Bahr, HFE NE II — 02/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/25/2016 (L20)

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DETERMINATION APPROVAL

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245399
February 25, 2016

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cc: Licensing and Certification File

MDH
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*of* Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 25, 2016

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1200 First Avenue Northeast
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RE: Project Number S5399026

Dear Ms. Walker:

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Enclosure

cc: Licensing and Certification File

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 245399 Y1 | A. Building<br>B. Wing Y2 | 2/18/2016 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LITTLE FALLS CARE CENTER | 1200 FIRST AVENUE NORTHEAST<br>LITTLE FALLS, MN 56345 |

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| ID Prefix F0279 | Correction | ID Prefix F0311 | Correction | ID Prefix F0314 | Correction |
| Reg. # 483.20(d), 483.20(k)(1) | Completed | Reg. # 483.25(a)(2) | Completed | Reg. # 483.25(c) | Completed |
| LSC | 01/31/2016 | LSC | 01/31/2016 | LSC | 01/31/2016 |
| ID Prefix F0323 | Correction | ID Prefix F0441 | Correction | ID Prefix F0465 | Correction |
| Reg. # 483.25(h) | Completed | Reg. # 483.65 | Completed | Reg. # 483.70(h) | Completed |
| LSC | 01/31/2016 | LSC | 01/31/2016 | LSC | 01/31/2016 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| | JS/KJ | 02/25/2016 | 35575 | 02/18/2016 |
| **REVIEWED BY CMS RO** ☐ | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |
| | | | | |

**FOLLOWUP TO SURVEY COMPLETED ON**
12/30/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

Certified Mail # 7011 0470 0000 5262 2687
February 12, 2016

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

Subject: Little Falls Care Center - IDR
Provider # 245399
Project # S5399026

Dear Ms. Walker:

This is in response to your letter dated 1/25/16, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency identified at tag F314 issued pursuant to the survey event XBVT11, completed on December 30, 2015.

The information presented with your letter, the CMS 2567 dated December 30, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

**F314 S/S - G 42 CFR §483.25 (c) Pressure Ulcers: Based on a comprehensive assessment of a resident, that–**
**(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and**
**(2) A resident having pressure sores receives necessary treatment and services to promote Healing, prevent infection and prevent new sores from developing.**

## Summary of the facility's reason for IDR of this tag:

The facility disputes findings related to the lack of providing services, completion of assessment, and implementation of interventions to promote and encourage the healing of pressure ulcers. The facility provided information which alleged the resident did not have open areas that met the criteria for pressure ulcers as the areas were not pressure related i.e. 'not over a bony promenience,' but rather were related to moisture associated skin damage (MASD). The facility indicated that determination was based on reviews by a certified wound nurse and a nurse practitioner (NP). The NP's note dated 12/30/15, indicated R14 had three open areas on the left mid-buttock; one of which had recently scabbed over on 12/27/15, but had re-opened. The NP indicated another one of the areas had started on 12/18/15, and was caused by friction due to R14 self propelling the wheelchair (w/c), sweating and

occasional incontinence episodes. The NP further remarked the open areas were not located over any bony prominence but were caused by a zipper on the seat cushion and indicated the administrator had confirmed R14 had a four inch foam cushion in the w/c. Thus, the facility alleged the open area was a skin injury, rather than pressure related.

## Summary of facts:

The facility provided an assessment (one page) for R14 dated 11/17/15, titled, General Nurse's Observation. The assessment indicated R14 had no open areas, and identified interventions in place to prevent pressure ulcers from developing. In addition, the assessment indicated the resident self propeled a w/c for mobility, however lacked any assessment for friction that may occur due to R14 self propeling the w/c. Review of the section described as "Skin Risk Assessment" (which the facility had underlined) noted non-applicable (N/A) for the area entitled, "Pressure redistributing, mattress on bed/cushion in chair in place, working and used according to manufacturer's recommendations? (What type/Gel/Air/Air-infused/memory foam?) Heel Protection?" The facility also did not comprehensively assess R14's wheelchair cushion which had a zipper, or the shearing potential from R14's self propelling of the wheelchair as potential risks for development of pressure ulcers.

According to a Minimum Data Set (MDS) dated 12/2/14, a pressure relieving device was identified as in use for R14. Subsequent MDS assessments lacked evidence of any pressure relieving devices being utilized for R14. In addition, the subsequent MDS assessments failed to identify whether a turning/repositioning shedule was in place, or whether the resident had a pressure relieving mattress.

In addition, according to a MDS dated 11/17/15, R14 did not have MASD. However the MDS conducted 8/20/15, indicated R14 did have MASD. Although R14 had a history of recurring MASD, R14's plan of care lacked any evidence of interventions initiated to minimize and or prevent further skin breakdown from the current MASD which the administrator and NP noted.

The MDS 3.0 manual dated 10/2015, directed facilities to determine whether a resident had any pressure ulcers: ... "3. Examine the resident and determine whether any ulcers, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing)." The MDS manual defined MASD as skin damage caused by moisture rather than pressure. According to the manual, if a resident had MASD, the facility was to provide care and services for optimal skin care, and early identification and treatment of minor cases, to help avoid progression and skin breakdown.

The Centers for Medicare and Medicaid (CMS) identify the following definition: "Pressure Ulcer- A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s).[15] Although friction and shear are not primary causes of pressure ulcers, friction and shear are important contributing factors to the development of pressure ulcers."

Although the facility asserted R14's skin breakdown was not over a bony prominence, but rather was

related to a zipper on the w/c cusion, or shearing while self propelling, the facility had not comprehensively assessed these known risk factors which had the potential to contribute to pressure ulcer development.

CMS guidance identifies references for facilities to utilize in order to be in compliance with the requirement at F314. The National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Treatment Quick Reference Guide dated 2009, directed staff to inspect the resident's skin around and under medical devices. R14's skin was not inspected when the pressure relieving cushion with the zipper was implemented for use.

## Summary of findings:

The administrator and NP indicated R14 currently utilized a pressure relieving cushion (medical device) on the wheelchair seat, to relieve pressure. However, it could not be determined when the cushion had been implemented, or whether the zipper on the cushion cover had been assessed or monitored. A facility form, General Nurse's Observation, the MDS assessments and the care plan, lacked documentation of assessment for use of the seat cushion. The facility's failure to comprehensively assess the w/c cushion, or shearing from self propelling the wheelchair as potential risk factors for the development of pressure ulcers, led to failure of the facility to implement adequate measures to prevent skin breakdown and promote wound healing.

As a result of this review, no modifications will be made to the details in the CMS 2567, and this will remain a valid deficiency at this tag and at the correct scope and severity (S/S) of a "G."

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-3792 Fax: 651-201-3790

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Jessica Sellner, St. Cloud Team B Unit Supervisor

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: XBVT

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

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

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

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

4. TYPE OF ACTION: **2** (L8)

| | |
|---|---|
| **1. Initial** | **2. Recertification** |
| **3. Termination** | **4. CHOW** |
| **5. Validation** | **6. Complaint** |
| **7. On-Site Visit** | **9. Other** |
| **8. Full Survey After Complaint** | |

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

6. DATE OF SURVEY **12/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements

Compliance Based On:

**X** 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 40 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
Amy Charais, HFE NE II — 01/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/04/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS
Posted 02/08/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
*of* Health

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 13, 2016

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

RE: Project Number S5399026

Dear Ms. Walker:

On December 31, 2015, 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 actual harm that is not immediate jeopardy (Level G), 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:

**Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**

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

**Remedies - 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;**

**Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

**DEPARTMENT CONTACT**

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

**Jessica Sellner, Unit Supervisor**
**Minnesota Department of Health**
**Licensing & Certification**
**Health Regulation Division**
**Midtown Square**
**3333 West Division, #212**
**St. Cloud, Minnesota 56301**
**Telephone: (320)223-7343**
**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 February 8, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 8, 2016 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

**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.

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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 March 31, 2016 (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 July 1, 2016 (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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245399 | A. BUILDING _____ B. WING _____ | 12/30/2015 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). | F 279 | | 1/31/16 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 01/22/2016 |

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.

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|---|---|---|---|---|
| F 279 | Continued From page 1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to develop a comprehensive plan of care for 1 of 2 residents (R55) reviewed activities of daily living (ADL's) who was at risk for pressure ulcers.<br><br>Findings include:<br><br>R55's admission Minimum Data Set (MDS) dated 11/10/2015, indicated R55 had severe cognitive impairment, required extensive assistance with bed mobility, tranfers, and toileting, and was at risk for developing pressure ulcers.<br><br>R55's careplan dated 11/19/15, indicated the resident was, "At risk for altered skin integrity related to incontinence." The care plan directed the staff to:" Provide pericare with each incontinent episode treatment as ordered." The care plan also indicated R55 was, "Independent in bed mobility," and directed staff, "Assist as requested with bed mobiltiy."<br><br>R55's Tissue Tolerance- Repostioning Observation (an assessment used to individually assess the skins ability to withstand pressure) dated 11/6/15, indicated the resident required staff assistance to be repositioned every 3 hours while sitting. The lying observarvation was not completed, and only had written, "Slept in recliner all noc [night] and self transfered." No further assessment was completed.<br><br>During observation on 12/29/15, at 6:50 p.m. R55 was observed during personal cares provided by nursing assistants (NA)-B and NA-D. R55 required total staff assistance for all cares and | F 279 | It is Little Falls Care Center□s policy to develop a comprehensive care plan for each resident.<br><br>R55□s Care Plan was reviewed and revised to reflect the resident□s current ADL status and repositioning needs to prevent skin breakdown.<br><br>All resident's at risk for skin breakdown (medium to high Braden score) will have Care Plans reviewed and updated quarterly, with any significant change and as needed to ensure they reflect current ADL status and repositioning needs.<br><br>Nursing staff were re-educated on R55□s and any other residents with updated ADL and Skin Care Plans on 12/30/15.<br><br>DON/designee will complete random audits of Care Plans of residents at risk for skin breakdown to ensure ADLs and repositioning needs are addressed, 3XwkX4, then weeklyX4 and monthly thereafter .<br><br>Audit results will be brought to the QAPI Committee for review and further recommendations. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 279 | Continued From page 2<br>bed mobility, and was assisted to transfer with the use of a mechanical lift and was placed on the toilet.<br><br>During interview on 12/29/15, at 6:50 p.m. NA-B and NA-D stated R55 required total staff assistance with all cares, was not able to reposition himself in bed or while sitting, and transfered with a mechanical lift.<br><br>During interview on 12/30/15, at 2:09 p.m. registered nurse (RN)-A and RN-B stated R55 required total to limited assistance from staff for all ADL's. RN-A stated R55's care plan had not been developed to include R55's ADL ability or direction to staff on how often to assist R55 with repositioning to prevent pressure ulcers. | F 279 | | |
| F 311 SS=D | 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS<br><br>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide assistance with grooming for 1 of 3 residents (R33) who required staff assistance with personal hygiene, and was observed to have facial hair.<br><br>Findings include:<br><br>R33's quarterly Minimum Data Set (MDS) dated 10/30/15, identified R33 had severe cognitive impairment, and required limited assistance from | F 311 | It is Little Falls Care Center's policy to ensure residents who require assistance with Activities of Daily Living, do receive the assistance needed.<br><br>R33 had facial hair removed on 12/30/15.<br><br>R33's Care Plan was updated to address R33's preference for family to remove facial hair. | 1/31/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 311 | Continued From page 3<br>staff with personal hygiene.<br><br>During observation on 12/28/15, at 10:46 a.m. R33 was seated in her wheelchair in the commons area with other residents doing arm band exercises. R33 had visible white and gray colored facial hair which was approximately one quarter inch long on her upper lip concentrated in the corners of her mouth. On 12/29/15, at 6:16 p.m. R33 was again observed and continued to have visible white and gray colored facial hair on her upper lip.<br><br>R33's care plan dated 1/19/15, identified R33 required, "Assistance with grooming and personal hygiene," and listed a goal for R33 to, "Be groomed neatly daily." The care plan did not identify any preference for R33 to have facial hair, the assistance required to remove it, or any direction to staff how often to remove it.<br><br>When interviewed on 12/29/15, at 6:25 p.m. nursing assistant (NA)-C stated R33 required, "Limited to extensive" help to complete her grooming and personal hygiene and does not typically refuse to allow cares. NA-C stated she was unaware of any preference for R33 to have visible facial hair, and observed R33's facial hair. NA-C stated R33 had, "A little hair" on her upper lip, and should have been shaved.<br><br>During interview on 12/29/15, at 7:22 p.m. licensed practical nurse (LPN)-A stated R33 required help to complete her personal hygiene and does not refuse staff assistance for cares. LPN-A observed R33's facial hair and stated she, "Does have some light fuzz [hair]," and stated it should be removed. LPN-A stated the facility did not have a community razor so shaving was not | F 311 | NAR Care sheets were updated to include R33's preference for family to remove facial hair.<br><br>NARs were re-educated on R33's POC and R33's preference to have family remove facial hair.<br><br>DON/designee will conduct random audits of facial hair 3XwkX4, then weekly X4 and monthly thereafter.<br><br>Audit results will be brought to the QAPI Committee for review and further recommendations. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 311 | Continued From page 4<br>always able to be completed timely for residents.<br><br>During interview on 12/30/15, registered nurse (RN)-A stated R33 had no preference to have facial hair, and it should have been removed on her most recent shower day or when staff noticed it.<br><br>A facility Shaving policy dated 12/30/14, identified, "To keep residents clean and well groomed." The policy directed any preference for a female resident to have facial hair would be identified in the care plan, and listed options for staff to follow for its removal which included, "On a weekly basis." | F 311 | | |
| F 314 SS=G | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to comprehensively assess, monitor, develop, and implement interventions to heal current pressure ulcers, and to reduce the risk for further development of pressure ulcers for 1 of 2 residents (R14) reviewed for pressure ulcers. This resulted in | F 314 | It is Little Falls Care Center's policy to ensure a resident does not develop an avoidable pressure sore, and if does present with a pressure sore will receive the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. | 1/31/16 |

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| F 314 | Continued From page 5<br>actual harm for R14 who developed multiple, reoccurring stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough; May also present as an intact or open/ ruptured blister) pressure ulcers to the buttocks.<br><br>Findings include:<br><br>R14's quarterly Minimum Data Set (MDS) dated 11/17/15, indicated the resident had no cognitive impairment, required extensive assistance with bed mobility, transfers, toileting, and was at risk for pressure ulcers but did not currently have a pressure ulcer.<br><br>R14's Care Area Assessment (CAA) dated 11/17/15, indicated R14 had, "Frequent redness in peri area and coccyx; Moisture associated skin damage (MASD)," and, "Re-occurring issue with abdomen and scrotum." The CAA indicated R14 currently had an open area that was, "Re-occurring on his left thigh," and directed R14 was to be repositioned every 2-3 hours, and lay down in bed once throughout the day to relieve pressure. However, the CAA indicated R14 was non-compliant with laying in bed, and the plan was to continue with the current plan to heal and, "Keep closed areas that are reoccurring." The CAA did not include any comprehensive assessment of the current skin conditions, any alternative interventions to direct staff on how to relieve pressure if R14 refused to lay down, nor did it address the resident's re occurring pressure ulcers on the buttocks.<br><br>R14's care plan dated 11/23/15, indicated the resident was independent with bed mobility, however, required extensive assist of two staff for | F 314 | On 12/30/15 a comprehensive Root Cause Analysis (RCA) was conducted by the facility's certified Wound Nurse for R14's three small open areas on his left lower buttock. They were not identified to be pressure related, rather were excoriation from a zipper on the resident's wheelchair cushion. The wheelchair cushion was replaced on 12/30/15.<br><br>The Nurse Practitioner visited on 12/30/15 and examined the resident's wounds and indicated 'they were not pressure related.'<br><br>R14's CP and NAR Care sheets were revised to reflect the updated interventions for R14's skin issue on 12/30/15.<br><br>All Nursing staff were re-educated on the resident's skin care plan on 12/30/15.<br><br>All residents with any skin wound were reviewed to ensure a comprehensive RCA was completed to identify the cause and type of wound with appropriate treatment in place to promote healing.<br><br>All Nursing staff received skin training by Corporate Wound Nurse Consultant on 1/25/16.<br><br>Random audits by the DON/designee will be conducted 2Xwk4, then weekly X 4, then monthly thereafter, to ensure all residents with skin wounds have a RCA with appropriate treatment, weekly wound round notes and tracking, and | |

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| F 314 | Continued From page 6<br>transfers using a mechanical stand. The care plan also directed staff to assist with changing brief and to provide peri care after each incontinent episode, to remind resident and assist to the toilet upon rising, every 2-3 houes during the day, and before bedtime. The care plan identified the resident was, "At risk for skin breakdown R/T [related to] diabetes mellitus," with interventions including, "Observe feet for evidence of problems, use tena wipes on abdominal fold and scrotum, dietary supplement as prescribed, and protein snacks provided at HS [hour of sleep]." The care plan did not address any current pressure ulcers, any pressure device or treatments being used, any interventions to heal or prevent pressure ulcers, nor did it direct staff on any repostioning schedule for R14.<br><br>R14's undated nursing assistant care sheet directed staff to encourage R14 to lie down after breakfast and lunch, and indicated the resident was independent with bed mobility, and independent with "repositioning and toileting," and instructed staff, "A1 [assist of one] repo [repositioning] as requested." The nursing assistant care sheet was 2 sided, and on the back side R14's "Toileting plan" was identified as, "A2 [assist of 2] pro lift [mechanical lift]: Toilet upon rising, q [every] 2-3 hours during day, at HS [hour of sleep] (blue pad, urinal/ commode)."<br><br>R14's most recent Tissue Tolerance-Repositioning Observation (an assessment used to individually assess the skins ability to withstand pressure) dated 11/16/15, indicated the resident had no current skin concerns. The lying observation indicated, "Independent with repositioning; Resident does not remain in one position," and indicated the resident used a | F 314 | interventions are care planned and being followed.<br><br>Audit results will be brought to the QAPI Committee for review and further recommendations. | |

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"Standard facility" mattress. The sitting observation indicated, "Does not remain in one position for 1 hour," and did not indicate if R14 was using a pressure reduction cushion in the chair or wheelchair.

During observation on 12/30/15, at 11:39 a.m. registered nurse (RN)-B assessed R14's left buttock, which had 3 open areas surrounded by a reddened area measuring 5 centimeters (cm) x 6 cm. RN-B measured the three separate open areas on R14's buttock and identified the following:

- The open area on top of the left buttock measured 0.7 cm x 1 cm.
- The middle open area measured 0.4 cm x 0.4 cm.
- The bottom area measured 0.6 cm x 0.3 cm.

RN-B described the open areas as, "Red epithelial tissue with a scant amount of drainage present."

R14's facility progress note dated 7/9/15, indicated R14 had, "Wounds on his bottom." There was no corresponding assessment which included location, measurements, or characteristics.

R14's facility progress note dated 8/18/15, indicated, "On right buttock has an open blister." There was no corresponding assessment which included location, measurements, or characteristics.

A General Nurse's Observation report dated 8/20/15, indicated R14 had an open blister to his right lower buttocks. The observation further

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indicated R14 was non-compliant with lying down to "take pressure off coccyx and peri-area."... "Frequent redness present in peri-area and coccyx." The observation further indicated, "New and history of past moisture associated skin damage, reposition every 2-3 hours and lay in bed once throughout the day." There was no evidence the repositioning schedule was carried through to R14's care plan or nursing assistant care sheet to ensure staff were aware of R14's specific interventions to heal the current pressure ulcers and/ or prevent pressure ulcers, nor was there any corresponding individualized assessment which was used to determine the repositioning schedule of every 2-3 hours.

R14's facility progress note dated 9/13/15, indicated, "Resident has been encouraged to lay down for a short period of time due to skin condition, but refused to do so."

A progress note dated 9/24/15, noted R14 had, "No current open areas." There was no ongoing monitoring of the buttock "blister" identified on 8/18/15, to determine when it resolved.

A progress note dated 10/14/15, indicated staff educated R14 regarding the need to lay down due to, "Wounds and open areas." However, the progress note did not identify where the open areas were located, nor did it include any characteristics or assessments of the open areas.

A General Nurse's Observation report dated 11/17/15, indicated R14 had reoccurring skin issues on abdomen and scrotum and, "Open area that is also reoccurring on his left thigh." The report further indicated moisture associated skin

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damage due to contact with urine, however, the report indicated R14 had only been incontinent one time during the assessment period. The note indicated non- compliance of recommendations of lying down to take pressure off coccyx and peri-area, however, there were no corresponding assessments, description, or location of the open areas, nor were there any further interventions put into place to relieve pressure.

A General Observation note dated 12/18/15, indicated R14 had an open area to the left lower buttocks measuring 1 cm x 1.4 cm which was draining. There was no further assessment of the open area.

A Skin Condition Report- Unhealed Daily wound assessment note dated 12/26/15, indicated, "Present on the left lower buttocks is a moisture associated skin damage (MASD). The following findings were documented, general comments: Moisture associated skin damage due to friction, sweating, and incontinence. Area scabbed and no drainage present. Surrounding skin intact and cool to the touch, site improvement noted, no recent changes were made to the treatment orders for this site, antibiotics are not currently in use, likelihood of healing due to overall condition, fair. Risk factors; decreased mobility, history of healed wounds, diabetes." Although the note indicated no changes in treatment were made, there was no indication what treatment had been used to promote healing of the pressure ulcers.

An Observation note dated 12/26/15, indicated, "Scabbed area to buttocks," due to "friction, sweating, and incontinence." There was no further assessment, description, or location of the scabbed area to the buttocks, nor were any

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further interventions put into place.

Although the progress notes and Wound Observation reports identified R14 had reoccurring stage II pressure ulcers to the buttocks, there was no ongoing monitoring of R14's skin to ensure current interventions and treatments were adequate to promote healing and prevent further pressure ulcers from developing. The assessments indicated R14 was not compliant with lying down twice daily, however, the facility did not reassess the resident to determine if further interventions could be attempted to ensure pressure was relieved to prevent further pressure ulcers from developing, and to ensure healing of the current stage II pressure ulcers on R14's buttocks.

During interview on 12/30/15, at 10:45 a.m. licensed practical nurse (LPN)-B stated R14 developed "chronic skin irritation" and was encouraged to lay down to relieve pressure areas. LPN-B was not aware of any further interventions in place to prevent and/ or heal R14's pressure ulcers.

During interview on 12/30/15, at 7:20 a.m. nursing assistant (NA)-A stated R14 had an open area on the back of his upper thigh that would come and go and had been there for over six months. NA-A stated R14 did not like to lay down during the day, and she was not aware of any other interventions to reposition or off-load (relieve pressure to an area to allow for reprofusion ) him to aid in prevention of further pressure ulcers.

During interview on 12/30/15, at 11:19 a.m. RN-A stated R14 had chronic, re-occurring "skin

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issues" and R14 did not like to lay down which contributed to the reoccurring pressure ulcers. RN-A was not aware of any specific interventions in place to heal/ prevent pressure ulcers except for encouraging R14 to lay down twice a day.

During interview on 12/30/15, at 11:51 a.m. RN-B stated the pressure ulcer on R14's buttocks was identified by her on 12/18/15. RN-B stated the "wounds" were a result of friction that was caused by his skin and clothing constantly moving against the wheelchair. RN-B stated staff talked to R14 about the risk of skin breakdown if he refused to lay down to relieve pressure, however, the facility had not developed any new interventions since the buttock pressure ulcers were identified. RN-B stated R14 was able to shift position in his chair independently, however, he was not able to off-load pressure without assistance from staff. RN-B was not aware of any other interventions in place to offload pressure for R14.

During interview on 12/30/15, at 12:56 p.m. director of nursing (DON) stated R14 had a history of open areas, and felt R14's wounds were not pressure ulcers, but resulted from friction due to slumping and adjusting himself in the chair. DON stated the RNs should assess and update the care plan related to each identified skin concern/ pressure ulcer at the time the area was identified, and a individualized comprehensive assessment should be completed to determine if new interventions were needed.

During interview on 12/30/15, at 1:30 p.m. R14 stated staff encourage him to lay down, however, he was often busy doing things and did not want to lay down for extended periods of time. R14 stated staff had not offered him any other options

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| F 314 | Continued From page 12<br>for offloading pressure aside from lying in his bed.<br><br>A facility pressure ulcer policy was requested but not provided. | F 314 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure medical equipment was powered in accordance with manufacturer recommendations to reduce the risk of electric shock and/or fire for 1 of 1 residents (R11) observed who had their oxygen concentrator plugged into an extension cord.<br><br>Findings include:<br><br>R11's significant change Minimum Data Set (MDS) dated 12/3/15, identified R11 had moderate cognitive impairment, and was on oxygen therapy.<br><br>During observation on 12/28/15, at 1:28 p.m. R11 was seated in a recliner chair in her room with a running "NewLife" Elite oxygen concentrator on the floor to her right side. R11 was wearing a nasal cannula which was connected to the | F 323 | It is Little Falls Care Center's policy to ensure the resident's environment remains free of accident hazards.<br><br>The extension cord was removed from R11's Oxygen concentrator and plugged directly into the wall.<br><br>The facility's Oxygen Administration policy was revised to include the Manufacturer's recommendation not to use an extension cord and to plug the device directly into the wall to reduce the potential for electric shock or fire.<br><br>All staff were re-educated on the updated Oxygen administration Policy on 1/12/16.<br><br>Director of Environmental Services/designee will conduct audits on a | 1/31/16 |

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| F 323 | Continued From page 13<br>running concentrator. The oxygen concentrator was plugged into a white "Power Sentry" multiple plug extension cord, which was plugged into an outlet behind her cloth recliner chair. During another observation on 12/29/15, at 5:18 p.m. R11 was again seated in her room wearing oxygen supplied by the running concentrator next to her recliner chair. The concentrator continued to be powered by the white extension cord, plugged into the outlet behind R11's cloth recliner chair.<br><br>During interview on 12/29/15, at 6:19 p.m. licensed practical nurse (LPN)-A stated R11 used the concentrator for oxygen at different periods throughout the day, and the concentrator was typically stored next to the recliner chair in her room. LPN-A observed the concentrator in R11's room and stated staff, "Don't typically plug them into power strips," and stated, "A wall outlet would be safest." LPN-A was unaware of the oxygen concentrators manufacturers recommendations regarding how to safely power the device.<br><br>An undated NewLife Elite Oxygen Concentrator Patient Manual identified several, "Important Safety Rules," for the use of the machine which included, "Do not use extension cords with this unit." Further, the manual provided an overview of the device, and under the, "Power Cord:" heading again identified, "Do not use extension cords with this unit."<br><br>During interview on 12/29/15, at 7:35 p.m. the director of nursing (DON) stated she was not aware of the manufacturers recommendations to not use electrical power strips to power the concentrators. The DON reviewed the manufacturers recommendations and stated | F 323 | weekly basis to ensure extension cords/power strips are not being used for oxygen concentrators.<br><br>Audit results will be brought to the QAPI Committee for review and further recommendations. | |

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| F 323 | Continued From page 14<br>R11's oxygen concentrator should not have been plugged into the power strip.<br><br>When interviewed on 12/30/15, at 9:09 a.m. an AirSep Corporation field service engineer stated they are the company who manufacturers the NewLife model oxygen concentrators, and using a power strip was, "Not recommended at all." The company had never tested them in that manner and there could be potential for a patient to sustain an electric shock, or an electrical fire if a power strip was used to power the device.<br><br>A facility Oxygen Administration policy dated 10/30/13, identified several safety precautions for staff to adhere to including proper storage and maintenance, however, the policy did not identify how to ensure the devices were powered in a safe manner to reduce potential electric shock or fire. | F 323 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections. | F 441 | | 1/31/16 |

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| F 441 | Continued From page 15<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement an infection control program to include consistent monitoring, trending, and analysis of infections to reduce the transmission to other residents in the facility. This had the potential to affect all 27 residents residing in the facility. In addition the facility failed to ensure handwashing was completed to reduce the potential spread of infection for 2 of 3 residents (R9, R21) who were observed during medication administration.<br><br>Findings include:<br><br>LACK OF COMPREHENSIVE INFECTION | F 441 | It is Little Falls Care Center's policy to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.<br><br>All Infection tracking will be on a single IC Surveillance Log that includes information on the organism cultured out, if was house acquired and the date of resolution.<br><br>Corporate Consultant reviewed the IC Surveillance Policy and procedures that include monitoring, trending and analysis, | |

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| F 441 | Continued From page 16<br>CONTROL PROGRAM<br><br>The infection control logs from July 2015, to December 2015, titled Infection Control Log were reviewed from 100 and 300 wing. The Infection Control Log identified the following information:<br>>Name<br>>Room<br>>Date of Onset of Infection<br>>Date of Admission<br>>"Inerited [sic]/Facility Acquired"<br>>Type/Site of Infection & Symptoms<br>>Date Culture Yes/No<br>>Date X-ray Yes/No<br>>Result of X-ray<br>>Antibiotic, start/end date, and if it was effective<br><br>The logs did not identify the type of organism, or the date the symptoms had resolved.<br><br>During interview on 12/30/15, at 7:33 a.m. director of nursing (DON), who was in charge of the infection control process, stated they had two different logs. The facility had monthly Infection Surveillance Logs which identified the same information as the Infection Control Logs with the addition of the pathogen, risk factors, preventive measures, and any follow up training that was completed with staff. The Infection Control Log tracked infections that were diagnosed and treated with antibiotics, and the Infection Surveillance Logs were used to track signs and symptoms of residents without any clinical diagnoses. There were different residents identified on each of these separate logs based on diagnoses, infection, or if they just had symptoms of an illness.<br><br>Review of the Infection Control Logs from | F 441 | with DON on 1/25/16.<br><br>Nursing staff were re-educated on hand washing between residents when administering medications and providing glucometer checks and other tasks from the medication cart.<br><br>DON/designee will conduct random audits of infection control (hand washing) during the medication pass, 3XwkX2, weeklyX2, then monthly thereafter.<br><br>Audit results will be brought to the QAPI Committee for review and further recommendations. | |

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| LITTLE FALLS CARE CENTER | 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345 |

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September 2015, through December 2015, did not identify any organisms, risk factors for residents, or date of resolution of the symptoms for the residents.

September 2015, Infection Control Logs identified 12 infections, with 6 skin/wound infections, 4 urinary tract infections, and 1 respiratory. The log also identified 1 antibiotic for "profolaxis for dental." There were 6 of the 12 infections identified as "acquired." There were no organisms identified or date of symptom resolution for any of the infections.

September 2015, Infection Surveillance Log, did not identify any resident infections.

October 2015, Infection Control Log identified 17 infections, with 6 residents with loose stools, 7 skin infections, 3 UTI, and 1 respiratory infection. There were 12 of 17 infections identified as "acquired". There were no organisms identified or date of symptom resolution.

October 2015, Infection Surveillance Log, identified 6 infections, but they were different resident than identified on the October 2015 Infection Control Log. All of the infections were identified as loose stools, and there was no indication if these were acquired infections.

November 2015, Infection Control Log identified 7 infections, with 2 skin, 3 UTI, 1 respiratory, and 1 loose stool. There were 6 of the 7 infections identified as "acquired." There were no organisms identified or date of symptom resolution.

November 2015, Infection Surveillance Log,

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identified 9 infections, but they were different resident than identified on the November 2015, Infection Control Log. Of these 9 infections there were 3 gastro intestinal symptoms; 5 shortness of breath with elevated temperature, and 1 resident with urinary incontinence and foul smelling urine (negative urinary analysis). There was no indication if these were acquired infections.

December 2015, Infection Control Log identified to date (12/30/15), there were 8 infections with 3 UTI, 3 respiratory infections, 1 skin infection, and 1 gastrointestinal symptoms. All of these infections were identified as "acquired." There were no organisms identified or date of symptom resolution.

December 2015, Infection Surveillance Log identified 4 infections, but they were different residents than identified on the December 2015, Infection Control Log. Of these 4 infections, all were gastrointestinal symptoms and there was no indication if these were acquired infections.

Also, review of the September 2015, to December 2015 Infection Control Logs identified R42 and R35's had reoccurring and multiple infections which were not consistently monitored for organism, and date of symptom resolution.

R42 was identified in the September Infection Control Log with an onset of a wound infection on 9/22/15, which was "Inerited [sic]", treated with Vancomycin, and Rifampin (both antibiotics used for resistive infections). There was no identification of the organism, no indication if or when the symptoms resolved, but indicated both the antibiotics were "effective."

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| F 441 | Continued From page 19 | F 441 | | |

R42 was identified in the October 2015, Infection Control Logs with an onset of infection on 9/22/15, for an "unknown/suspected infection", and was on Rifampin, however, there was no organism identified, but under the effectiveness column it was noted as, "ongoing."

R42 was not identified in the November 2015, Infection Control Log, however, there was no reference that R42 infection had resolved.

R42 was identified in the December 2015, Infection Control Log with an onset of skin infection on 9/22/15, with "redness around infection, pain, increase in draining 'yellow'" and was treated with Amoxicillian (antibiotic), which was "effective." There was no organism identified to determine if this was the correct antibiotic, nor was there any date of resolution of the symptoms, however, it was again noted as "effective."

R35 was identified in October 2015, Infection Control Log, with an onset of an "acquired" infection on 9/20/15, for "skin infection" and "knee joint infection post surgical." R35 received Rifampin, and ceftriaxon (both antibiotics), on 9/20/15. The Rifampin was identified as "not effective", and was started on clindiamycin, on 10/13/15, for "skin infection post surgical." The effectiveness of the clindiamycin was identified as "ongoing." There was no indication the organism was identified by the facility to determine if these were the correct antibiotic for R35's infection. R35 was not identified on the November, or December Infection Control Logs, even though he had an "ongoing" infection in October.

The above information was reviewed with the DON on 12/30/15, at 7:33 a.m. and she stated

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| F 441 | Continued From page 20<br>she reviewed and gathered the information, and brings the information to quality assurance. Although the facility had two separate reports, one for antibiotic use, and the other for symptom identification, these reports lacked organism identification, risk factors for residents, if acquired in house or not, no date of symptom resolution, no trending of the collected data, or analysis to determine if infectious disease was spreading in the facility or if education to the staff was required.<br>The facility policy titled Little Falls Care Center 6.0 Infection Prevention and Control Program, issued 4/10, identified on page 2 of 4 under Surveillance Program, "The infection Control (ICP) Professional will conduct a surveillance program that includes: assessing the population, electing outcomes measures, collecting surveillance data on a daily basis, analyzing and reporting the surveillance data as necessary."<br><br>During observation of medication administration on 12/28/15, at 11:50 a.m., licensed practical nurse (LPN)-A was observed performing an accucheck (use of a fingerstick device for blood glucose monitoring) for R4, and then administered insulin into R4's abdomen. LPN-A had worn gloves during the procedure, and after completion of administering the insulin injection, LPN-A removed the gloves and left the room without performing hand hygiene. LPN-A returned to the medication cart at the nurse's station, and without washing her hands or using hand sanitizer, removed medications from the medication cart for R9 and placed them into a medication cup. LPN-A entered R9's room, donned gloves, and performed an accucheck. | F 441 | | |

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LPN-A removed the gloves, used a stethoscope to listen to R9's lungs, left R9's room without performing hand hygiene, and walked down the hallway to the medication cart at the nurse's station. LPN-A answered the portable telephone and transferred a call, typed information into the computer on the medication cart, pulled open the drawer on the medication cart, and proceeded to prepare an insulin pen for R9 without performing hand hygiene. LPN-A obtained two gloves from the medication cart and walked back to R9's room, donning the gloves. LPN-A entered R9's room, administered the insulin, removed the gloves, and then held them in her right hand with the syringe, and left the room without performing hand hygiene. LPN-A walked to the medication cart and threw the gloves in the trash can attached to the medication cart. Without performing hand hygiene, LPN-A opened the drawers on the medication cart, and poured medications into a medication cup for R21. LPN-A walked to R21's room and administered the oral medications without performing any hand hygiene.

During interview on 12/28/15, at 12:15 p.m. LPN-A stated she should have performed hand hygiene after removing gloves with accucheck's, before and after insulin administration, and after each resident contact.

During an interview on 12/30/15, at 2:00 p.m. director of nursing (DON) stated staff should wash or sanitize hands between residents, especially after accucheck's or giving insulin.

A review of the facility's policy titled Hand Hygiene dated 9/1/15, indicated staff should perform hand hygiene before having direct contact with

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| F 441 | Continued From page 22<br>residents, after having direct contact with a resident's skin, after having contact with body fluids, and before putting on and after removing gloves used as a protective barrier. | F 441 | | |
| F 465 SS=C | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility kitchen failed to ensure all ventilation openings were clean of dust and debris, and failed to ensure floor mats were maintained in a clean and sanitary manner. This had the potential to affect all 27 residents who consumed food from the kitchen.<br><br>Findings include:<br><br>During the initial tour of the facility kitchen with cook (CK)-A on 12/28/15, at 8:35 a.m. the vent directly above the stove and food preparation area was noted to have several clumps of dust on the vent frame. The vent was V shaped with filters on either side, and a steel bar running up the middle of the filters was coated with a brown fuzzy substance. The bottom frame which was approximately four inches wide had numerous areas of dust hanging down approximately one inch. Also observed was an anti-fatigue mat approximately 2.5 feet wide by 6 feet long on the floor behind the warming table which was noted | F 465 | It is Little Falls Care Center's policy to provide a sanitary environment in the kitchen.<br><br>The vent above the stove was cleaned on 12/30/15.<br><br>The anti-fatigue mat behind the warming table was removed on and the floor was cleaned on 1/19/16.<br><br>The kitchen cleaning schedule was reviewed and revised to ensure the vent above the stove and the floors are cleaned appropriately and timely.<br><br>The Dietary manager/designee will conduct audits of the kitchen vents and kitchen floor 3XwkX2, then weekly thereafter to ensure cleaning schedule for vent above the stove and floor is being followed. | 1/31/16 |

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| F 465 | Continued From page 23<br>to have cracked/broken off edges around the perimeter, and a black substance on the floor surrounding the mat.<br><br>During interview on 12/28/15, at 8:35 a.m. CK-A stated the maintenance department was in charge of cleaning the vents, and stated the dust hanging on the steel was not sanitary and it should be cleaned.<br><br>Review of the facility forms dated 10/08, titled Maintenance/Housekeeping Monthly were reviewed for the months of September - December 2015, identified the hood filters were cleaned 9/3/15, and 11/19/15, however, inside and outside of the hood were documented as being cleaned last on 11/19/15.<br><br>During observation on 12/30/15, at 7:14 a.m. CK-B was observed making french toast in two frying pans on the stove top, directly below the unclean vents. Dust remained visible on the areas as noted 12/28/15, and had not been cleaned.<br><br>When interviewed on 12/30/15, at 7:28 a.m. CK-B stated maintenance clean the vents above the stove and they were expected to do this monthly. CK-B stated multiple, "dust bunnies" were visible directly above the stove and should be cleaned.<br><br>During interview on 12/30/15, at 7:40 a.m. maintenance (M)-A stated the metal slats on the vent should be run through the dishwasher, and the metal frame should be wiped down at the same time. Vents in the kitchen were visualized by M-A at this time, and he stated dust was observed to be hanging down from the metal between the filters, as well as some areas | F 465 | Audit results will be brought to the QAPI Committee for review and further recommendations. | |

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| F 465 | Continued From page 24 | F 465 | | |

approximately one inch from the bottom frame. M-A stated maintenance was in charge of cleaning the vents and filters, and stated the dates noted on the monthly cleaning log was the last time the vents were cleaned, and stated the vents were not sanitary.

When interviewed on 12/30/15, at 9:39 a.m. dietary manager (DM) stated maintenance was informed when she puts up the new cleaning scheduled. DM stated she had noted the dust on the vent, and had notified M-A to come and clean the vents. DM stated all 27 residents receive food prepared in the kitchen, and it was not sanitary to prepare food with dust above the stove. She stated housekeeping was in charge of cleaning the floors and mat in the kitchen every day, and it was her expectation they clean the floor underneath the mat.

When interviewed on 12/30/15, at 1:05 p.m. housekeeper (H)-A stated the floor in the kitchen is cleaned only when two housekeepers are scheduled, and this week only one is scheduled. When they do clean the floor, they sweep and mop, and only go over the top of the mats.

When interviewed on 12/30/15, at 1:11 p.m. M-A stated he oversees housekeeping, and the housekeepers are expected to sweep and mop the kitchen every day after lunch, and are expected to remove the mat to clean underneath. He verified the mat would not be considered clean or safe, as it has chips along the perimeter, and is taped in a couple of places to the floor. M-A was not aware housekeeping was not cleaning the kitchen floors if only one housekeeper was scheduled, and also stated he rarely goes into the kitchen.

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| F 465 | Continued From page 25<br><br>The facility undated policy titled Cleaning Instructions: Cleaning Hoods and Filters, noted stove hoods and filters will be cleaned according to the cleaning schedule, or at least monthly. To clean the interior and exterior of the hood, use a clean cloth soaked in soapy detergent water. Rinse thoroughly and air dry. A more abrasive cleaning agent may be needed in some cases. A cleaning agent that can handle grease may be needed.<br><br>The facility undated policy titled Cleaning Instructions: Cleaning Floors, Tables and Chairs indicated kitchen and dining room floors, tables, and chairs will be kept clean and sanitary. Kitchen floors will be swept two times a day and cleaned daily. A thorough cleaning using a disinfectant will be done at least twice a week. | F 465 | | |

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| | 245399 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **12/29/2015** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Little Falls Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>Lutheran Care Center is a 1 story building with no basement. It was constructed at four different times. The original building was built in the 1964 and was determined to be of a Type II(222) construction. In 1975 an addition was added to the east of 200 Wing that was determined to be Type II (222) construction. In 1992 an addition was added to the west of 100 Wing that was determined to be Type II (000) construction. In 2001 an addition was added to the southwest that was determined to be Type II(000).<br><br>The facility is fully protected by a fire sprinkler system. The building has a fire alarm system with automatic smoke detectors down the corridors with additional automatic smoke detection in all common use spaces which is monitored for automatic fire department notification. Because the original building and the 3 additions are of the same type of construction type allowed for existing buildings, the facility was surveyed as one building.<br><br>The facility has a capacity of 40 beds and had a census of 27 at the time of the survey. | K 000 | | |

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.

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