Electronically delivered
April 25, 2019

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

RE: Project Number H5399023C

Dear Administrator:

On April 23, 2019, 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. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will 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.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Electronically delivered
March 26, 2019

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

RE: Project Number H5399023C

Dear Administrator:

On March 13, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the March 13, 2019 abbreviated survey, the Minnesota Department of Health completed an investigation of complaint number H5399023C.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is April 22, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of 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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- 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 (488.456(b)).

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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 if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 13, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 13, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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.

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	C 03/13/2019

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 On 3/13/19, an abbreviated standard survey was conducted to investigate complaint H5399023C. The complaint was substantiated with deficiencies cited at F689 and F725. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		4/22/19

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

Electronically Signed | 04/04/2019

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 688	Continued From page 1 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative ambulation programs for 4 of 6 residents (R3, R4, R5, R6) reviewed for range of motion and mobility and who were assessed as needing these programs to promote mobility. Findings include: R3's quarterly Minimum Data Set (MDS) dated 1/15/19, identified R3 had intact cognition and required extensive assistance with transfers and ambulation in her room. Further, R3 had no functional limitations in range of motion (ROM). R3's care plan printed 3/13/19, identified R3 required assistance to ambulate using a walker. A section labeled, "Restorative," identified R3 was at risk for a decline in ambulation due to poor balance and gait, and listed an intervention which directed, "Walk program 3 [times] week." On 3/13/19, at 9:38 a.m. nursing assistant (NA)-A was interviewed and stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility. A provided Maple Island - Group A and Maple Island Group B listing, each dated 3/11/19, identified each resident and their respective interventions and restorative nursing programs.	F 688	R3- reviewed restorative ambulation program and updated program. Staff caring for R3 were re-educated on her ambulation program. R4- reviewed restorative ambulation program and updated program. Staff caring for R4 were re-educated on her ambulation program. R5- reviewed and revised Maple Island group sheet specific to R5 care needs. Request forwarded to therapy to screen for ambulation program. Will update R5□s care plan for ambulation based on the therapy recommendations. R6- reviewed restorative ambulation program and updated program. Staff caring for R6 were re-educated on her ambulation program. All residents that are on ambulation programs have the potential to be affected by a deficient practice. All residents with restorative ambulation programs will be reviewed. Staff will be re-educated on the ambulation programs as needed DON or designee will complete random audits to ensure programs are completed as written. 2 random audits will be completed weekly for 4 weeks, then 1/week for 4 weeks, then monthly thereafter. Audit results will be brought to the full quarterly QAPI for review and further recommendations.	

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F 688	Continued From page 2	F 688		

These sheets identified R3's name with an intervention directing, "Rest/walk 250ft [feet]."

On 3/13/19, at 10:15 a.m. R3 was seated in a recliner chair in her room. R3 had no visible contractures or ROM deficits visible. When interviewed at this time, R3 stated none of the staff had been walking with her. R3 added, "I wish they would."

R3's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R3's walking program had been completed. R3's distance walked and minutes spent walking were recorded which identified R3 completed only seven days of her walking program in January 2019; only five days of her walking program in February 2019; and, only two days thus far of her walking program in March 2019.

R4's quarterly MDS dated 2/22/19, identified R4 had intact cognition. In addition, R4's care plan printed 3/13/19, identified R4 required extensive assistance with ambulation and directed, "Walk to dining room at least once/day and walk around the unit once/day." Further, a section labeled, "Restorative," directed R4 was at risk for decline in ambulation along with an intervention which read, "Ambulate with [walker] and transfer belt 2 X [times] daily up to 400 ft."

On 3/13/19, at 10:34 a.m. R4 was seated in a recliner chair in her room. R4 had no visible contractures or limitations visible in her ROM. R4 was interviewed, and explained she was not being assisted with walking. R4 expressed, "Not even once a day, not even minutes." R4 felt her ability to walk had not declined; however, stated she would like to be walking with staff like she

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F 688	Continued From page 3	F 688		

was supposed to. R4 added, "I don't know what the deal is here."

A provided Lindbergh Park - Group B listing dated 3/11/19, identified R4's name along with specific interventions for her care. These included, "Walk [twice daily] [with walker] up to 400 [feet]."

When interviewed on 3/13/19, at 11:11 a.m. NA-B stated the restorative programs were not consistently done on the unit as there was not a consistent restorative aide scheduled. NA-B added, "We're working on it."

R4's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R4's walking program had been completed. R4's distance walked and minutes spent walking were recorded which identified R4 completed only two days of the walking program in January 2019. No entries were recorded for February or March 2019.

R5's significant change MDS dated 1/3/19, identified R5 had moderate cognitive impairment and required extensive assistance with his ADLs. Further, R5 had no recorded limitations in functional ROM.

On 3/13/19, at 9:38 a.m. NA-A stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility.

A provided Maple Island - Group A listing dated 3/11/19, identified R5's name along with specific

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F 688	Continued From page 4	F 688		

interventions for his care. The listing directed R5 had a restorative nursing program in place which read, "Walk 250ft daily."

On 3/13/19, at 10:59 a.m. R5 was seated in his room in a wheelchair finishing a nebulizer treatment. R5 had no obvious ROM deficits while seated in the chair. When interviewed, R5 stated "very little" of his walking was being done. R5 explained staff had not been helping him with his walking for several weeks and he had "been waiting for them" to start it again as he would like to walk more.

R5's care plan printed 3/13/19, lacked any evidence or direction R5 was on a restorative program for ambulation despite the provided Maple Island - Group A listing directing he was.

R5's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, was requested; however, none was provided.

R6's annual MDS dated 1/3/19, identified R6 had intact cognition and required extensive assistance with ADLs. Further, R6 had no limitations in functional ROM recorded. In addition, R6's care plan printed 3/13/19, identified R6 required assistance to ambulate due to poor balance. A section labeled, "Restorative," directed R6 was at risk for a decline in ambulation ability and provided an intervention which read, "Resident on walk program 3x week."

On 3/13/19, at 9:38 a.m. NA-A was interviewed and stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person

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F 688	Continued From page 5 assigned was pulled to work on the floor instead due to the poor staffing levels in the facility. A provided Maple Island - Group A listing dated 3/11/19, identified R6's name along with specific interventions for her care. The listing directed R6 had a restorative nursing program in place which read, "Walk 30 ft daily." R6's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R6's walking program had been completed. R6's distance walked and minutes spent walking were recorded which identified R6 completed only three days of the walking program in February 2019. No entries were recorded for January or March 2019. On 3/13/19, at 2:11 p.m. the director of nursing (DON) was interviewed. DON reviewed the provided Walking Therapy Detail Report(s) for each of the resident(s) reviewed and stated they were not being completed as directed by their care plans or restorative programs. DON explained she was aware the programs weren't being done and the facility was working to hire someone to put the restorative nursing program "back into place." Further, DON stated the programs should be completed to help promote resident independence. A facility policy on restorative nursing programs was not provided.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		4/22/19

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F 689	Continued From page 6 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assessed and care planned interventions to prevent falls were implemented for 1 of 3 residents (R2) reviewed for falls. Findings include: R2's quarterly Minimum Data Set (MDS) dated 2/19/19, identified R2 moderate cognitive impairment and was independent with transfers and walking in his room. R2's care plan printed 3/13/19, identified R2 was at risk for falls and injury related to a history of falls. A goal was listed for R2 to remain free of falls or injury, and several interventions were identified to help R2 meet this goal. These interventions included, "Anti-slip strips strips [sic] next to bed, in front of sink and toilet." On 3/13/19, at 9:35 a.m. R2 was seated in his wheelchair in the chapel waiting for church service to begin. R2's room was observed; however, there were no visible anti-slip strips installed on the floor next to the bed, nor inside the bathroom next to the toilet or sink. During subsequent observation on 3/13/19, at 11:34 a.m. R2 was seated in his wheelchair in the bathroom of his room looking into the mirror	F 689	R2- anti-slip strips were placed in front of sink and toilet, next to the bed on Right side, in front of recliner and under recliner on 3/13/19. All residents that have interventions developed after falls have the potential to be affected if they are not implemented. All staff were re-educated on implementation of fall interventions. DON or designee will complete audits to ensure fall interventions that are developed are implemented. All falls will be audited for 30 days to ensure developed interventions are implemented. Then 2 fall incidents weekly for 2 weeks, then 1/week for 2 weeks, then monthly thereafter. Audit results will be brought to the full quarterly QAPI for review and further recommendations.	

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F 689	Continued From page 7	F 689		

above the sink. R2 had shoes on his feet at this time. R2 stated he had fallen in his bathroom a "couple weeks ago" which resulted in him laying on the floor for a long time before someone found him. R2 added, "My balance ain't very good." Further, R2 stated his bathroom used to have black colored strips on the floor; however, they were gone now and he didn't know why or for how long they had been gone.

On 3/13/19, at 11:39 a.m. nursing assistant (NA)-A observed R2's room with the surveyor and verified the lack of installed anti-slip strip(s) in the bathroom or next to the bed. NA-A explained there used to be strips installed; however, she was unable to recall how long ago she had last seen them. During the interview, NA-A called over to housekeeper (HK)-A who was present and questioned her about the strips not being installed on R2's floor. HK-A stated R2 used to have them; however, she had removed the last strip because it was peeling away from the floor and bunching up. HK-A explained she created a maintenance slip for them to be replaced; however, she was not able to recall how long ago this happened.

When interviewed on 3/13/19, at 11:45 a.m. the assistant director of nursing (ADON) stated R2 should have anti-slip strips installed in his room on the floor because he "tends to slip on the floor" when he removes his gripper socks and walks barefooted. R2 was considered a "pretty high fall risk" and obtained a laceration on his head when he last fell in his bathroom a couple weeks prior. ADON added the strips were installed at that time in the bathroom as she recalled seeing them.

A provided Fall Prevention and Management

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F 689	Continued From page 8 policy dated 10/2017, identified each resident would be assessed for their fall risk on admission, quarterly and with any significant changes. The policy continued, " ... and will identify interventions to help prevent falls, and/or to prevent injuries from falls."	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		4/22/19

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	245399	A. BUILDING _____ B. WING _____	C 03/13/2019

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

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F 725	Continued From page 9 Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed needs for 4 of 6 residents (R3, R4, R5, R6) reviewed for range of motion, and 3 of 3 residents (R7, R8, R9) observed to be assisted with meals in the commons area. In addition, for 4 of 4 staff members (NA-A, NA-B, LPN-A, RN-A) who voiced concerns with a lack of sufficient nursing staff within the facility. Findings include: ASSESSED NEEDS NOT MET: R3's care plan printed 3/13/19, identified R3 required assistance to ambulate using a walker. A section labeled, "Restorative," identified R3 was at risk for a decline in ambulation due to poor balance and gait, and listed an intervention which directed, "Walk program 3 [times] week." On 3/13/19, at 9:38 a.m. nursing assistant (NA)-A was interviewed and stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility. On 3/13/19, at 10:15 a.m. R3 was seated in a recliner chair in her room. R3 had no visible contractures or ROM deficits visible. When interviewed at this time, R3 stated none of the staff had been walking with her. R3 added, "I wish they would." R3's Walking Therapy Detail Report dated 1/1/19	F 725	The facility will ensure that appropriate amount of staff are available to ensure ROM and dining needs are met for all residents. Staffing schedules were reviewed. Changes were made to the schedules to ensure restorative programs are completed according to care plans. Meal time schedules were reviewed and updated to increase the staff available to assist with mealtimes in the dining rooms. Staff will be assigned to assist residents in the dining rooms. Administrator will ensure audits to ensure appropriate staffing are developed and implemented. All schedules will be audited for 30 days to ensure developed interventions are implemented. Then 2 fall incidents weekly for 2 weeks, then 1/week for 2 weeks, then monthly thereafter. Audit results will be brought to the full quarterly QAPI for review and further recommendations.	

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F 725	Continued From page 10	F 725		

to 3/13/19, identified the dates and times R3's walking program had been completed. R3's distance walked and minutes spent walking were recorded which identified R3 completed only seven days of her walking program in January 2019; only five days of her walking program in February 2019; and, only two days thus far of her walking program in March 2019.

R4's care plan printed 3/13/19, identified R4 required extensive assistance with ambulation and directed, "Walk to dining room at least once/day and walk around the unit once/day." Further, a section labeled, "Restorative," directed R4 was at risk for decline in ambulation along with an intervention which read, "Ambulate with [walker] and transfer belt 2 X [times] daily up to 400 ft."

On 3/13/19, at 10:34 a.m. R4 was seated in a recliner chair in her room. R4 had no visible contractures or limitations visible in her ROM. R4 was interviewed, and explained she was not being assisted with walking. R4 expressed, "Not even once a day, not even minutes." R4 felt her ability to walk had not declined; however, stated she would like to be walking with staff like she was supposed to. R4 added, "I don't know what the deal is here."

When interviewed on 3/13/19, at 11:11 a.m. NA-B stated the restorative programs were not consistently done on the unit as there was not a consistent restorative aide scheduled. NA-B added, "We're working on it."

R4's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R4's walking program had been completed. R4's

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F 725	Continued From page 11	F 725		

distance walked and minutes spent walking were recorded which identified R4 completed only two days of the walking program in January 2019. No entries were recorded for February or March 2019.

R5's name along with specific interventions for his care were identified on a provided Maple Island - Group A listing dated 3/11/19. The listing directed R5 had a restorative nursing program in place which read, "Walk 250ft daily."

On 3/13/19, at 9:38 a.m. NA-A stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility.

On 3/13/19, at 10:59 a.m. R5 was seated in his room in a wheelchair finishing a nebulizer treatment. R5 had no obvious ROM deficits while seated in the chair. When interviewed, R5 stated "very little" of his walking was being done. R5 explained staff had not been helping him with his walking for several weeks and he had "been waiting for them" to start it again as he would like to walk more.

R6's care plan printed 3/13/19, identified R6 required assistance to ambulate due to poor balance. A section labeled, "Restorative," directed R6 was at risk for a decline in ambulation ability and provided an intervention which read, "Resident on walk program 3x week."

On 3/13/19, at 9:38 a.m. NA-A was interviewed and stated the facility staffing was "horrible."

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F 725	Continued From page 12	F 725		

NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility.

R6's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R6's walking program had been completed. R6's distance walked and minutes spent walking were recorded which identified R6 completed only three days of the walking program in February 2019. No entries were recorded for January or March 2019.

On 3/13/19, at 2:11 p.m. the director of nursing (DON) was interviewed. DON reviewed the provided Walking Therapy Detail Report(s) for each of the resident(s) reviewed and stated they were not being completed as directed by their care plans or restorative programs. DON explained she was aware the programs weren't being done and the facility was working to hire someone to put the restorative nursing program "back into place." Further, DON stated the programs should be completed to help promote resident independence.

REFER TO F688 FOR ADDITIONAL INFORMATION.

RESIDENT / STAFF CONCERNS:

R4's quarterly MDS dated 2/22/19, identified R4 had intact cognition. When interviewed on 3/13/19, at 10:34 a.m. R4 explained she was not being assisted with walking, "Not even once a day, not even minutes." R4 stated she would like

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F 725	Continued From page 13	F 725		

to be walking with staff like she was supposed to and added, "I don't know what the deal is here." Further, R4 expressed the facility was short staffed and stated she didn't even use her call light anymore as staff "take so long" to respond and answer it. R4 added, "I just get up and go do it [whatever she needs]." Further, R4 stated the staff even voice complaints to her in which they report "they can't get enough staff."

On 3/13/19, at 9:38 a.m. the commons area of the Maple Island unit was observed. R7, R8 and R9 were all seated at a table being assisted with eating by activities assistant (AA)-A. At the same time, several residents were gathered in the chapel waiting for mass to begin, and numerous other residents on the unit were in their rooms.

When interviewed on 3/13/19, at 11:27 a.m. licensed practical nurse (LPN)-A stated R7, R8 and R9 were cognitively impaired and are "typically" left in bed until after breakfast is served as there was not enough staff to help get them out of bed timely and down to the dining room. LPN-A explained the staff worked short several times a pay period with some days only having one nurse and one NA to care for over 25 residents. This caused medications to be administered late and caused overtime just to get assigned charting done "almost everyday." The NA staff were not completing the restorative programs everyday, nor were second baths always being provided due to the "rough" staffing levels within the facility. Further, LPN-A stated the poor staffing had been an issue for "months" and the management team was aware of these concerns often voicing to staff, "[they are] doing everything we can do."

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F 725	Continued From page 14 During interview on 3/13/19, at 2:27 p.m. registered nurse (RN)-A stated she felt the facility needed more staff to ensure resident' needs were met. The facility seemed to work short on a "pretty regular" basis and both of the units really needed two aides working on them. RN-A explained she frequently "ends up being an aide" due to being short staffed which causes her not to be able to do her assigned RN task(s). Further, RN-A stated the short staffing "makes it a challenge to get things done" and, at times, medications were being passed late as nurses were having to help on the floor with cares. On 3/13/19, at 2:27 p.m. the administrator and director of nursing (DON) were interviewed and explained the facility staffed their nursing services using case mix along with resident needs. They try to schedule two NA staff on each unit; however, they don't always have the availability of staff to do so so, at times, the nurses are pulled to work on the floor. The DON explained the Maple Island unit had more independent residents, so that side was the one which went with only one NA when needed. The administrator stated every care center will have staff who report not having enough staff, and explained they recently added an extra eight hours a day for a 'support aide' to help with the "non-clinical" aspect of the NA role, such as passing water and making beds. Further, the administrator and DON stated they were adding other things to make the staff more engaged which they hoped would cause more recruitment and retention of the NA staff. The provided Facility Assessment dated 10/1/18, identified the facility had an average daily census of 44 (July 2017 to July 2018) and served	F 725		

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F 725	Continued From page 15 residents with psychiatric, heart, neurological, and infectious diseases. A completed, "Unit Staffing Analysis" was included for each unit. Maple Island was listed as having 32 active beds, and staffed with NA(s) at 3.21 hours per resident in a 24 hour period. Lindbergh Park was listed as having 32 beds, and staffed with NA(s) at 3.49 hours per resident in a 24 hour period. A facility policy on staffing was not provided.	F 725		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered March 26, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Number H5399023C

Dear Administrator:

A complaint investigation was completed on March 13, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 licensing 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 violation. Please remember that this provision is only a suggestion 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 violation within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 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 investigator's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/13/19, an abbreviated survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint(s) was/were found to be substantiated: H5399023C - Correction order(s) issued at MN 0800 MN 0830 and MN 0915. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide sufficient nursing staff to meet assessed needs for 4 of 6 residents (R3, R4, R5, R6) reviewed for range of motion, and 3 of 3 residents (R7, R8, R9) observed to be assisted with meals in the commons area. In addition, for 4 of 4 staff members (NA-A, NA-B, LPN-A, RN-A) who voiced concerns with a lack of sufficient nursing staff within the facility. Findings include:	2 800	The facility will ensure that appropriate amount of staff are available to ensure ROM and dining needs are met for all residents. Staffing schedules were reviewed. Changes were made to the schedules to ensure restorative programs are completed according to care plans. Meal time schedules were reviewed and updated to increase the staff available to	4/22/19

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2 800	Continued From page 2 ASSESSED NEEDS NOT MET: R3's care plan printed 3/13/19, identified R3 required assistance to ambulate using a walker. A section labeled, "Restorative," identified R3 was at risk for a decline in ambulation due to poor balance and gait, and listed an intervention which directed, "Walk program 3 [times] week." On 3/13/19, at 9:38 a.m. nursing assistant (NA)-A was interviewed and stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility. On 3/13/19, at 10:15 a.m. R3 was seated in a recliner chair in her room. R3 had no visible contractures or ROM deficits visible. When interviewed at this time, R3 stated none of the staff had been walking with her. R3 added, "I wish they would." R3's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R3's walking program had been completed. R3's distance walked and minutes spent walking were recorded which identified R3 completed only seven days of her walking program in January 2019; only five days of her walking program in February 2019; and, only two days thus far of her walking program in March 2019. R4's care plan printed 3/13/19, identified R4 required extensive assistance with ambulation and directed, "Walk to dining room at least once/day and walk around the unit once/day."	2 800	assist with mealtimes in the dining rooms. Staff will be assigned to assist residents in the dining rooms. Administrator will ensure audits to ensure appropriate staffing are developed and implemented. All schedules will be audited for 30 days to ensure developed interventions are implemented. Then 2 fall incidents weekly for 2 weeks, then 1/week for 2 weeks, then monthly thereafter. Audit results will be brought to the full quarterly QAPI for review and further recommendations.	

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2 800	Continued From page 3 Further, a section labeled, "Restorative," directed R4 was at risk for decline in ambulation along with an intervention which read, "Ambulate with [walker] and transfer belt 2 X [times] daily up to 400 ft." On 3/13/19, at 10:34 a.m. R4 was seated in a recliner chair in her room. R4 had no visible contractures or limitations visible in her ROM. R4 was interviewed, and explained she was not being assisted with walking. R4 expressed, "Not even once a day, not even minutes." R4 felt her ability to walk had not declined; however, stated she would like to be walking with staff like she was supposed to. R4 added, "I don't know what the deal is here." When interviewed on 3/13/19, at 11:11 a.m. NA-B stated the restorative programs were not consistently done on the unit as there was not a consistent restorative aide scheduled. NA-B added, "We're working on it." R4's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R4's walking program had been completed. R4's distance walked and minutes spent walking were recorded which identified R4 completed only two days of the walking program in January 2019. No entries were recorded for February or March 2019. R5's name along with specific interventions for his care were identified on a provided Maple Island - Group A listing dated 3/11/19. The listing directed R5 had a restorative nursing program in place which read, "Walk 250ft daily." On 3/13/19, at 9:38 a.m. NA-A stated the facility staffing was "horrible." NA-A expressed "none" of	2 800		

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2 800	Continued From page 4 the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility. On 3/13/19, at 10:59 a.m. R5 was seated in his room in a wheelchair finishing a nebulizer treatment. R5 had no obvious ROM deficits while seated in the chair. When interviewed, R5 stated "very little" of his walking was being done. R5 explained staff had not been helping him with his walking for several weeks and he had "been waiting for them" to start it again as he would like to walk more. R6's care plan printed 3/13/19, identified R6 required assistance to ambulate due to poor balance. A section labeled, "Restorative," directed R6 was at risk for a decline in ambulation ability and provided an intervention which read, "Resident on walk program 3x week." On 3/13/19, at 9:38 a.m. NA-A was interviewed and stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility. R6's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R6's walking program had been completed. R6's distance walked and minutes spent walking were recorded which identified R6 completed only three days of the walking program in February 2019. No entries were recorded for January or March 2019.	2 800		

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2 800	Continued From page 5 On 3/13/19, at 2:11 p.m. the director of nursing (DON) was interviewed. DON reviewed the provided Walking Therapy Detail Report(s) for each of the resident(s) reviewed and stated they were not being completed as directed by their care plans or restorative programs. DON explained she was aware the programs weren't being done and the facility was working to hire someone to put the restorative nursing program "back into place." Further, DON stated the programs should be completed to help promote resident independence. REFER TO F688 FOR ADDITIONAL INFORMATION. RESIDENT / STAFF CONCERNS: R4's quarterly MDS dated 2/22/19, identified R4 had intact cognition. When interviewed on 3/13/19, at 10:34 a.m. R4 explained she was not being assisted with walking, "Not even once a day, not even minutes." R4 stated she would like to be walking with staff like she was supposed to and added, "I don't know what the deal is here." Further, R4 expressed the facility was short staffed and stated she didn't even use her call light anymore as staff "take so long" to respond and answer it. R4 added, "I just get up and go do it [whatever she needs]." Further, R4 stated the staff even voice complaints to her in which they report "they can't get enough staff." On 3/13/19, at 9:38 a.m. the commons area of the Maple Island unit was observed. R7, R8 and R9 were all seated at a table being assisted with eating by activities assistant (AA)-A. At the same time, several residents were gathered in the chapel waiting for mass to begin, and numerous	2 800		

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2 800	Continued From page 6 other residents on the unit were in their rooms. When interviewed on 3/13/19, at 11:27 a.m. licensed practical nurse (LPN)-A stated R7, R8 and R9 were cognitively impaired and are "typically" left in bed until after breakfast is served as there was not enough staff to help get them out of bed timely and down to the dining room. LPN-A explained the staff worked short several times a pay period with some days only having one nurse and one NA to care for over 25 residents. This caused medications to be administered late and caused overtime just to get assigned charting done "almost everyday." The NA staff were not completing the restorative programs everyday, nor were second baths always being provided due to the "rough" staffing levels within the facility. Further, LPN-A stated the poor staffing had been an issue for "months" and the management team was aware of these concerns often voicing to staff, "[they are] doing everything we can do." During interview on 3/13/19, at 2:27 p.m. registered nurse (RN)-A stated she felt the facility needed more staff to ensure resident' needs were met. The facility seemed to work short on a "pretty regular" basis and both of the units really needed two aides working on them. RN-A explained she frequently "ends up being an aide" due to being short staffed which causes her not to be able to do her assigned RN task(s). Further, RN-A stated the short staffing "makes it a challenge to get things done" and, at times, medications were being passed late as nurses were having to help on the floor with cares. On 3/13/19, at 2:27 p.m. the administrator and director of nursing (DON) were interviewed and explained the facility staffed their nursing services	2 800		

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2 800	Continued From page 7 using case mix along with resident needs. They try to schedule two NA staff on each unit; however, they don't always have the availability of staff to do so so, at times, the nurses are pulled to work on the floor. The DON explained the Maple Island unit had more independent residents, so that side was the one which went with only one NA when needed. The administrator stated every care center will have staff who report not having enough staff, and explained they recently added an extra eight hours a day for a 'support aide' to help with the "non-clinical" aspect of the NA role, such as passing water and making beds. Further, the administrator and DON stated they were adding other things to make the staff more engaged which they hoped would cause more recruitment and retention of the NA staff. The provided Facility Assessment dated 10/1/18, identified the facility had an average daily census of 44 (July 2017 to July 2018) and served residents with psychiatric, heart, neurological, and infectious diseases. A completed, "Unit Staffing Analysis" was included for each unit. Maple Island was listed as having 32 active beds, and staffed with NA(s) at 3.21 hours per resident in a 24 hour period. Lindbergh Park was listed as having 32 beds, and staffed with NA(s) at 3.49 hours per resident in a 24 hour period. A facility policy on staffing was not provided. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure that adequate policy and programs are developed for sufficient staffing based on the resident population so residents received safe, adequate and timely assistance with toileting, bathing, repositioning, pressure ulcer care, and	2 800		

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2 800	Continued From page 8 eating assistance. The facility could educate staff on these policies and perform routine evaluations of resident care to ensure residents are receiving care and services for adequate staffing. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assessed and care planned interventions to prevent falls were implemented for 1 of 3 residents (R2) reviewed for falls. Findings include:	2 830	R2- anti-slip strips were placed in front of sink and toilet, next to the bed on Right side, in front of recliner and under recliner on 3/13/19. All residents that have interventions developed after falls have the potential to	4/22/19

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2 830	Continued From page 9 R2's quarterly Minimum Data Set (MDS) dated 2/19/19, identified R2 moderate cognitive impairment and was independent with transfers and walking in his room. R2's care plan printed 3/13/19, identified R2 was at risk for falls and injury related to a history of falls. A goal was listed for R2 to remain free of falls or injury, and several interventions were identified to help R2 meet this goal. These interventions included, "Anti-slip strips strips [sic] next to bed, in front of sink and toilet." On 3/13/19, at 9:35 a.m. R2 was seated in his wheelchair in the chapel waiting for church service to begin. R2's room was observed; however, there were no visible anti-slip strips installed on the floor next to the bed, nor inside the bathroom next to the toilet or sink. During subsequent observation on 3/13/19, at 11:34 a.m. R2 was seated in his wheelchair in the bathroom of his room looking into the mirror above the sink. R2 had shoes on his feet at this time. R2 stated he had fallen in his bathroom a "couple weeks ago" which resulted in him laying on the floor for a long time before someone found him. R2 added, "My balance ain't very good." Further, R2 stated his bathroom used to have black colored strips on the floor; however, they were gone now and he didn't know why or for how long they had been gone. On 3/13/19, at 11:39 a.m. nursing assistant (NA)-A observed R2's room with the surveyor and verified the lack of installed anti-slip strip(s) in the bathroom or next to the bed. NA-A explained there used to be strips installed; however, she was unable to recall how long ago she had last	2 830	be affected if they are not implemented. All staff were re-educated on implementation of fall interventions. DON or designee will complete audits to ensure fall interventions that are developed are implemented. All falls will be audited for 30 days to ensure developed interventions are implemented. Then 2 fall incidents weekly for 2 weeks, then 1/week for 2 weeks, then monthly thereafter. Audit results will be brought to the full quarterly QAPI for review and further recommendations.	

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2 830	Continued From page 10 seen them. During the interview, NA-A called over to housekeeper (HK)-A who was present and questioned her about the strips not being installed on R2's floor. HK-A stated R2 used to have them; however, she had removed the last strip because it was peeling away from the floor and bunching up. HK-A explained she created a maintenance slip for them to be replaced; however, she was not able to recall how long ago this happened. When interviewed on 3/13/19, at 11:45 a.m. the assistant director of nursing (ADON) stated R2 should have anti-slip strips installed in his room on the floor because he "tends to slip on the floor" when he removes his gripper socks and walks barefooted. R2 was considered a "pretty high fall risk" and obtained a laceration on his head when he last fell in his bathroom a couple weeks prior. ADON added the strips were installed at that time in the bathroom as she recalled seeing them. A provided Fall Prevention and Management policy dated 10/2017, identified each resident would be assessed for their fall risk on admission, quarterly and with any significant changes. The policy continued, " ... and will identify interventions to help prevent falls, and/or to prevent injuries from falls." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review care plan interventions with staff, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 915	Continued From page 11	2 915		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services 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 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative ambulation programs for 4 of 6 residents (R3, R4, R5, R6) reviewed for range of motion and mobility and who were assessed as needing these programs to promote mobility. Findings include: R3's quarterly Minimum Data Set (MDS) dated 1/15/19, identified R3 had intact cognition and required extensive assistance with transfers and ambulation in her room. Further, R3 had no functional limitations in range of motion (ROM).	2 915	R3- reviewed restorative ambulation program and updated program. Staff caring for R3 were re-educated on her ambulation program. R4- reviewed restorative ambulation program and updated program. Staff caring for R4 were re-educated on her ambulation program. R5- reviewed and revised Maple Island group sheet specific to R5 care needs. Request forwarded to therapy to screen for ambulation program. Will update R5□s care plan for ambulation based on	4/22/19

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2 915	Continued From page 12 R3's care plan printed 3/13/19, identified R3 required assistance to ambulate using a walker. A section labeled, "Restorative," identified R3 was at risk for a decline in ambulation due to poor balance and gait, and listed an intervention which directed, "Walk program 3 [times] week." On 3/13/19, at 9:38 a.m. nursing assistant (NA)-A was interviewed and stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility. A provided Maple Island - Group A and Maple Island Group B listing, each dated 3/11/19, identified each resident and their respective interventions and restorative nursing programs. These sheets identified R3's name with an intervention directing, "Rest/walk 250ft [feet]." On 3/13/19, at 10:15 a.m. R3 was seated in a recliner chair in her room. R3 had no visible contractures or ROM deficits visible. When interviewed at this time, R3 stated none of the staff had been walking with her. R3 added, "I wish they would." R3's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R3's walking program had been completed. R3's distance walked and minutes spent walking were recorded which identified R3 completed only seven days of her walking program in January 2019; only five days of her walking program in February 2019; and, only two days thus far of her walking program in March 2019.	2 915	the therapy recommendations. R6- reviewed restorative ambulation program and updated program. Staff caring for R6 were re-educated on her ambulation program. All residents that are on ambulation programs have the potential to be affected by a deficient practice. All residents with restorative ambulation programs will be reviewed. Staff will be re-educated on the ambulation programs as needed. DON or designee will complete random audits to ensure programs are completed as written. 2 random audits will be completed weekly for 4 weeks, then 1/week for 4 weeks, then monthly thereafter. Audit results will be brought to the full quarterly QAPI for review and further recommendations.	

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2 915	Continued From page 13 R4's quarterly MDS dated 2/22/19, identified R4 had intact cognition. In addition, R4's care plan printed 3/13/19, identified R4 required extensive assistance with ambulation and directed, "Walk to dining room at least once/day and walk around the unit once/day." Further, a section labeled, "Restorative," directed R4 was at risk for decline in ambulation along with an intervention which read, "Ambulate with [walker] and transfer belt 2 X [times] daily up to 400 ft." On 3/13/19, at 10:34 a.m. R4 was seated in a recliner chair in her room. R4 had no visible contractures or limitations visible in her ROM. R4 was interviewed, and explained she was not being assisted with walking. R4 expressed, "Not even once a day, not even minutes." R4 felt her ability to walk had not declined; however, stated she would like to be walking with staff like she was supposed to. R4 added, "I don't know what the deal is here." A provided Lindbergh Park - Group B listing dated 3/11/19, identified R4's name along with specific interventions for her care. These included, "Walk [twice daily] [with walker] up to 400 [feet]." When interviewed on 3/13/19, at 11:11 a.m. NA-B stated the restorative programs were not consistently done on the unit as there was not a consistent restorative aide scheduled. NA-B added, "We're working on it." R4's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R4's walking program had been completed. R4's distance walked and minutes spent walking were recorded which identified R4 completed only two days of the walking program in January 2019. No entries were recorded for February or March	2 915		

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2 915	Continued From page 14 2019. R5's significant change MDS dated 1/3/19, identified R5 had moderate cognitive impairment and required extensive assistance with his ADLs. Further, R5 had no recorded limitations in functional ROM. On 3/13/19, at 9:38 a.m. NA-A stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility. A provided Maple Island - Group A listing dated 3/11/19, identified R5's name along with specific interventions for his care. The listing directed R5 had a restorative nursing program in place which read, "Walk 250ft daily." On 3/13/19, at 10:59 a.m. R5 was seated in his room in a wheelchair finishing a nebulizer treatment. R5 had no obvious ROM deficits while seated in the chair. When interviewed, R5 stated "very little" of his walking was being done. R5 explained staff had not been helping him with his walking for several weeks and he had "been waiting for them" to start it again as he would like to walk more. R5's care plan printed 3/13/19, lacked any evidence or direction R5 was on a restorative program for ambulation despite the provided Maple Island - Group A listing directing he was. R5's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, was requested; however, none was provided.	2 915		

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2 915	Continued From page 15 R6's annual MDS dated 1/3/19, identified R6 had intact cognition and required extensive assistance with ADLs. Further, R6 had no limitations in functional ROM recorded. In addition, R6's care plan printed 3/13/19, identified R6 required assistance to ambulate due to poor balance. A section labeled, "Restorative," directed R6 was at risk for a decline in ambulation ability and provided an intervention which read, "Resident on walk program 3x week." On 3/13/19, at 9:38 a.m. NA-A was interviewed and stated the facility staffing was "horrible." NA-A expressed "none" of the walking programs were being completed on her unit as "[we] don't have a restorative [aide] right now." The person assigned was pulled to work on the floor instead due to the poor staffing levels in the facility. A provided Maple Island - Group A listing dated 3/11/19, identified R6's name along with specific interventions for her care. The listing directed R6 had a restorative nursing program in place which read, "Walk 30 ft daily." R6's Walking Therapy Detail Report dated 1/1/19 to 3/13/19, identified the dates and times R6's walking program had been completed. R6's distance walked and minutes spent walking were recorded which identified R6 completed only three days of the walking program in February 2019. No entries were recorded for January or March 2019. On 3/13/19, at 2:11 p.m. the director of nursing (DON) was interviewed. DON reviewed the provided Walking Therapy Detail Report(s) for each of the resident(s) reviewed and stated they were not being completed as directed by their	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00382	A. BUILDING: _____ B. WING _____	C 03/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 915	Continued From page 16 care plans or restorative programs. DON explained she was aware the programs weren't being done and the facility was working to hire someone to put the restorative nursing program "back into place." Further, DON stated the programs should be completed to help promote resident independence. A facility policy on restorative nursing programs was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could hire additional person(s) to complete the programs or review applicable procedures to ensure the programs are being implemented as ordered. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		