DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 9, 2021

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

RE: CCN: 245399
Cycle Start Date: January 12, 2021

Dear Administrator:

On March 22, 2021, we notified you a remedy was imposed. On March 31, 2021 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 12, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 12, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 2, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 12, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 12, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
March 22, 2021

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

RE: CCN: 245399
Cycle Start Date: January 21, 2021

Dear Administrator:

On February 2, 2021, we informed you that we may impose enforcement remedies.

Compliance with the health deficiencies cited on January 21, 2021 has not yet been verified.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 12, 2021. (42 CFR 488.417 (b))

The CMS Region V Office will notify your Medicare Adminstrative Contractor (MAC) that the denial of payment for new admissions is effective April 12, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 12, 2021. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Little Falls Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 12, 2021. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Delivered Electronically

February 25, 2021

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

Subject: Little Falls Care Center – Administrative review 2567 modification
CMS Certification Number (CCN): # 245399
Event ID: ATZJ11

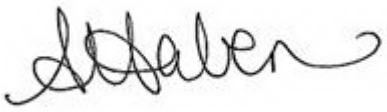
Dear Administrator:

This is notice of an administrative review of a citation cited at tag F600 issued pursuant to the survey Event ID ATZJ11, completed on January 12, 2021 as a part of MDH's Quality Assurance review. As a result of this review, it was determined the deficiency cited did not represent an immediate jeopardy situation, and confirmed you had already implemented corrective action to remove the deficient practice prior to our onsite survey.

Since we have determined this is not a valid example of a current deficient practice under this regulation, it will be removed from the Statement of Deficiencies.

A revised Statement of Deficiencies is attached.

Sincerely,



Susie Haben, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 320-223-7356

cc: Office of Ombudsman for Long-Term Care
Pam Malterud, Assistant Program Manager
Licensing and Certification File

Electronically delivered
February 2, 2021

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

RE: CCN: 245399
Cycle Start Date: January 12, 2021

Dear Administrator:

On January 12, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 12, 2021 (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 July 12, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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 _____	C 01/12/2021

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 Revised 2567 as a result of a MDH's Quality Assurance review. On 1/6/21 through 1/12/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5399044C-MN67086 H5399043C-MN68136 H5399045C-MN63100 with a deficiency cited at F689 As a result of the investigations other deficiencies were also identified at F609. The following complaint was found to be UNSUBSTANTIATED: H5399046C-MN60152 H5399040C-MN64840 H5399041C-MN62488 H5399042C MN64803 and MN64842 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/12/2021

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

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F 000	Continued From page 1 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		4/12/21

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F 609	Continued From page 2 Based on interview and document review, the facility failed to report an allegation of resident to resident abuse to the State Agency within two hours for 2 of 3 residents (R4, R5) reviewed for timely reporting of abuse allegations. Findings include: R4's admission minimal data set (MDS) dated 11/24/20, indicated R4 had diagnoses that included anxiety disorder and hip fracture. Staff also indicated that R4 does have short and long term memory problems with moderately impaired cognitive skills for daily decision making. R4's care plan dated 1/7/21, indicated resident was vulnerable related to cognitive status and physical condition. R5's quarterly MDS dated 10/28/20, indicated R5 had diagnoses that included dementia, anxiety disorder, and depression. R5's progress note dated 12/11/20, indicated "Resident was physically abused by another (R4) accusing her of taking her room. A visitor (family member (FM)-A) in the next room witnessed the incident and reported." Internal investigation report dated 1/7/21, indicated R5 entered R4's room insisting that it was R5's room. R5 and R4 were talking loudly. R5 then became upset with R4 and FM-A witnessed R5 kick R4 on R4's shin. FM-A was able to intervene until staff was present and took R5 back to R5's room. On 1/6/21, at 12:50 p.m. family member (FM)- A indicated on 12/11/20, she witnessed R5 kick R4	F 609	It□s LFHS policy to report alleged violations of abuse, neglect, or mistreatment in a timely manner. Administrator and/or designee will implement corrective action for resident R4 affected by this practice. Administrator and/or designee will implement measures to ensure that this practice does not reoccur. All facility staff will be re-educated on the proper procedure for Maltreatment Reporting including the types of maltreatment or abuse and guidelines for timely reporting. Licensed nurses were re-educated on the importance of notifying the Administrator immediately. The Administrator and/or designee will monitor corrective actions to ensure the effectiveness of these actions including Social Services will interview random residents 5x/week x1 week, then 3x/week x 4weeks, then monthly until QAPI committee determines no longer needed. Administrator will monitor corrective actions by completing random audits on allegations of maltreatment of a vulnerable adult that were reported to the State Agency to ensure they were reported timely. Audits will be completed daily x 1 week, 3x/week x 4weeks, then monthly x then monthly until QAPI committee determines no longer needed. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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F 609	Continued From page 3	F 609		

and she reported the incident immediately to RN-A on 12/11/20.

On 1/6/21, at 2:17 p.m. licensed social worker (LSW) indicated she was made aware of the incident on the morning of 12/14/21, when LSW reviewed progress notes. LSW reported the incident and began the investigation. LSW stated the incident should have been reported "right after it happened". Further, LSW stated everyone is a mandated reporter, and there is a vulnerable adult (VA) reference book but staff are able to contact the director of nursing (DON) or administrator with questions.

On 1/6/21, at 2:29 p.m. registered nurse (RN)-A confirmed he wrote the progress note in R5's record dated 12/11/20. RN-A indicated he was notified of the incident "in passing" on 12/11/20, by family member (FM)-A who witnessed R5 kick R4. Further, RN stated that the report he received was not that R5 kicked R4, at that time it was a verbal contradiction. However, progress note dated 12/11/20,written by RN-A, does use the verbiage of physically abused. RN-A stated they were going to email the DON due to it being well past business hours. However, RN-A stated "most definitely should have reported soon after, but I don't know the time frame for reporting abuse." RN-A indicated the facility had trained RN-A on reporting abuse and there is a template in the VA book to follow. RN-A stated they would report physical, financial, sexual abuse, and neglect within "48 hours or its 12 hours, I am not sure."

On 1/7/21, at 10:12 a.m. DON stated the incident occurred on 12/11/20, but she was not made aware of incident until 12/14/20. DON indicated

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F 609	Continued From page 4	F 609		

all licensed nursing staff have access for making the initial report to the SA. Further, DON stated this incident should have been reported "that evening" and this incident would have needed to be reported within 24 hours due to no injury.

On 1/7/21, at 10:56 a.m. Administrator indicated the incident occurred on 12/11/20, around 4:00 p.m. and was made aware of incident on 12/14/20. Further, Administrator indicated licensed nurses are trained on initial reporting. Administrator stated staff were expected to report abuse "per facility policy and use our VA book to determine when something should be reported to me, DON, or the state." However, when asked about when incident should have been reported, Administrator stated "abuse is to be reported immediately. Abuse is a willful infliction of injury with resulting physical harm pain or mental anguish, but because there was no harm to the resident I don't believe it [the incident] would fall into the category of abuse."

On 1/7/21, at 11:16 a.m. registered nurse (RN)-B stated they were made aware of the incident on 12/14/20, and then notified DON. Further, RN-B indicated they would report "anything that warrants a VA, like physical or verbal and things of that matter would report immediately. This incident should have been reported upon the moment of the incident."

On 1/7/21, at 11:55 a.m. DON confirmed abuse should be reported "immediately if there is an injury, it's two hours, if there is no injury 24 hours. This incident should have been reported within 24 hours since there was no injury."

On 1/7/21, at 12:10 p.m. licensed practical nurse

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F 609	Continued From page 5 (LPN)-A indicated on 12/12/20, when report was given at the beginning of shift it was reported that there was an altercation between R5 and R4, however was not notified if it had already been reported. Further, LPN-A stated "our protocol is whoever sees it or is on shift should report it to the nurse that is there" and would report immediately if any signs of physical abuse. Facility policy Maltreatment Prohibition Policy dated 2/19/18, defines immediately as "soon as possible, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." Facility policy Training Employees on Maltreatment Prohibition Policy dated 2/19/18, indicated "staff will be instructed on the reporting mechanism for this care center. Staff are informed that they are considered 'mandated reporters' if they should observe any one mistreating a VA in any of the ways that are definition is considered 'abuse' or 'neglect.'"	F 609		
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 - §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.	F 689		4/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement care plan interventions to prevent the likelihood of potential falls for 2 of 3 (R4 and R7) residents. Findings include: R7's facesheet undated, identified diagnosis of Alzheimer disease, delusional disorders, hallucinations, major depressive disorders, previous hip fracture. R7's minimum data set dated 9/17/20, identified severe cognitive impairment. R7 requires extensive with transfers and bed mobility. R7's Care plan revised 11/12/20, indicated at risk for falls or injury related to cognitive deficits with interventions of non skid strips on floor by bed and toilet, foot pedals to be used during wheelchair mobility provided by staff. During observation on 1/11/21, at 1:10 p.m. R7's floor in bedroom and bathroom had no anti slip stickers on the floor by the bed or by the toilet. R7's bed was pushed against the wall with only one bed rail on bed on the side opposite of the wall. During interview on 1/11/21, at 1:16 p.m. nursing assistant (NA)-A stated R7 is a falls risk and is to have bed in low position with the mat on the floor. NA-A stated she doesn't believe that R7 has the anti skid strips on the floor. During interview on 1/11/21, at 1:43 p.m. NA-B stated R7 was to have anti skid strips on the floor	F 689	It is LFHS policy to ensure that Residents are free from Hazards/Supervision/Devices and residents environment remains as free of accidents hazards as possible. Facility Fall Prevention and Management policy was reviewed by DON. On 1/12/21 R7 had Grip Strips placed on the floor by her bed and in her bathroom. On 1/12/21 R7 had bilateral grab bars placed on bed. On 1/12/21 R4 had anti-slip materiel replaced under her fall mat. On 1/14/21, Facility implemented a room-move email checklist to ensure care plan interventions are put into place when residents move rooms. On 2/9/21 Nursing staff were re-educated on the importance of following the residents care plan/ NAR group sheet assignments. Director of Nursing and/or designee will complete random audits on care plan interventions in relation to falls 5x/week x 1 week, 3x/week x 4weeks, and weekly until QAPI committee determines no longer needed. Director of Nursing and/or designee will correct issues identified through audits, including adding interventions and training staff as needed. Audits will be brought to the next QAPI meeting to be evaluated for effectiveness.	

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incase she would try to stand up since she has dementia and is a falls risk.

During interview on 1/11/21, at 2:32 p.m. NA-C stated R7 is a falls risk and according to her care plan that indicates non skid grips to be on floor by bed and bathroom and stated they appear to be missing. NA-C further stated with looking at her care plan that it shows she should have 2 bed rails on her bed and it only has one. NA-C stated that they interventions are put in place to help with reposition of resident and to prevent falls. NA-C stated that if these are missing they would notify the nurse, charge nurse or maintenance so they could put these back in place.

During observation on 1/12/21, at 6:55 a.m. R7 laying in bed with once side rail on bed, no anti skid grips noted on floor next to bed or in bathroom.

During phone interview on 1/12/21, at 9:24 a.m. registered nurse (RN)-A stated that if an intervention is on the care plan she would expect that it is in place. Stated interventions are put in place to prevent R7 from falling. R7 stated that if staff were aware that interventions were not in place she would expect them to notify nurse immediately so the intervention could be put back in place.

During interview on 1/12/21, at 10:10 a.m. Director of Nursing (DON) stated R7 is a falls risk. DON looked at care plan and on care plan stated that she should have two bed rails on bed and anti grip strips on the floor by bed and in bathroom. DON stated she is not sure if these are still current as she has not gotten up by herself in a while and would need to speak with the case

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manager. DON further stated these interventions are put in place for safety.

R4's facesheet dated 1/7/21, identified diagnosis of Alzheimer's disease.

R4's admission minimum data set (MDS) dated 11/24/20, indicated R4 requires extensive assist of two staff for bed mobility, transfers, toileting and personal hygiene.

R4's care plan dated 1/7/21, indicated at risk for falls or injury related to recent diagnosis of left hip and wrist fracture. Further, care plan indicated interventions consisted of anti-slip material under fall mat.

Progress note dated 11/18/20, indicated R4 was found on knees, upper torso on the bed, and two abrasions on knees.

Facility document titled Lindbergh Park-Group A printed on 1/7/21, indicated R4 safety interventions included: low bed, fall mats, bilateral bed rails, roam guard left ankle, anti-roll backs, assess footwear, and fall mats out of reach when not in use. Further, document indicated staff to frequently check R4, care-planned to place self on floor out of bed, and offer naps more frequently, and anti-slip material under fall mats were typed in bold.

During observation on 1/11/21, at 1:56 p.m. R4 was laying in bed, with bed at lowest position with floor mat placed on floor, however there were no anti-slip material under the floor mat.

On 1/11/21, at 2:22 p.m. NA-D stated R4 was considered to be a fall risk. NA-D referenced

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Lindberg Park-Group A document. When asked about the bolded letters for anti-slip material under mat, NA-D stated it is bolded because it is either the "most important or it is new."

On 1/11/21, at approximately 2:22 p.m. R4 continued to lay in bed. NA-D entered R4's room and lifted up R4's floor mat and stated "they should be under the mat and there is one that goes on each side. We should have checked on rounds but that slipped my mind I won't lie about that. We did not look." Further, NA-D stated she was unable to find the anti-slip material and exited R4's room.

During continuous observation on 1/11/21, from 2:32 through 3:03 p.m. R4 continued to lay in bed and no anti-slip material was placed under floor mat.

On 1/12/21, at 9:16 a.m. RN-B stated R4 was consider a fall risk and majority of R4's falls have been out of bed. RN-B indicated falls interventions are placed on the Lindberg Park document to guide the nursing assistants and "if it is a newer task or if I want it to stick out I will bold it." RN-B confirmed anti-slip material under fall mat was bolded related to R4 had been known to sit on edge of bed and kick the mat away from the bed. Further, RN-B indicated staff were expected to place the material under the fall mat when R4 is in bed for safety and to prevent the mat from slipping if R4 were to slide out of bed or kick the mat.
On 1/12/21, at 9:33 a.m. LPN-B identified R4 as a fall risk. LPN-B referenced Lindberg Park document for interventions related to fall risk and indicated anti-slip material was bolded related to it being a new intervention for R4. Further, LPN-B

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stated it was important for staff to place the material under the mat to "to give more grip to stay in place if she tries to crawl out of bed and that makes her more of a fall risk and if that mat slips she is more opt to fall."

On 1/12/21, at 10:15 a.m. DON identified R4 as a fall risk and to prevent further injury anti-slip under the mat was an intervention if R4 does fall or put herself on the floor "we want to protect her and the fall to be as safe as possible." Further, DON indicated staff were expected to check for the anti-slip material and if it was not there to place it under the mat.

Policy Fall prevention and Management dated 10/12/17, indicated "The facility will assess each resident for their fall risk on admission, quarterly and with any significant change in condition and will identify interventions to help prevent falls, and/or prevent injuries from falls. if a fall occurs, staff will conduct a root cause analysis to identify interventions to prevent subsequent falls and/or injury from further falls" "Fall Risk assessment: If a resident's fall risk score is >/= to 9, a comprehensive fall assessment will be completed to identify resident's history of falls, activity level, visual impairment, balance and gait, elimination status and diagnoses and medications, etc. that can contribute to falls. The data gathered will be analyzed. A summary will be completed and interventions will be developed and implemented to mitigate the resident's fall risk."

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F 000	INITIAL COMMENTS Revised 2567 as a result of a MDH's Quality Assurance review. On 1/6/21 through 1/12/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5399044C-MN67086 H5399043C-MN68136 H5399045C-MN63100 with a deficiency cited at F689 As a result of the investigations other deficiencies were also identified at F609. The following complaint was found to be UNSUBSTANTIATED: H5399046C-MN60152 H5399040C-MN64840 H5399041C-MN62488 H5399042C MN64803 and MN64842 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/12/2021

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

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F 000	Continued From page 1 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 1 (R4) of 3 residents, when R5 was observed to kick R4's shin. Findings include: R4's admission minimal data set (MDS) dated 11/24/20, indicated R4 had diagnoses that included anxiety disorder and hip fracture. Staff also indicated that R4 does have short and long term memory problem with moderately impaired cognitive skills for daily decision making.	F 600	It is LFHS policy to keep residents free from abuse, neglect, and exploitation. Director of Nursing and/or designee will implement corrective action for resident R4, affected by this practice. A photo of R4 and R5 have been placed at eye level on their respective door frames as an intervention to assist residents in determining which room belongs to them. Director of Nursing and/or designee will monitor corrective actions to ensure the effectiveness of these actions including: Social Services will interview random	4/12/21

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F 600	Continued From page 2 R4's care plan dated 1/7/21, indicated resident was vulnerable related to cognitive status and physical condition. R5's quarterly MDS dated 10/28/20, indicated R5 had diagnoses that included dementia, anxiety disorder, and depression. R5's progress note dated 12/11/20, indicated "Resident was physically abused by another (R4) accusing her of taking her room. A visitor (family member (FM)-A) in the next room witnessed the incident and reported." However, per interviews and investigation report, R5 was the alleged perpetrator, who was witnessed to kick R4. Internal investigation report dated 1/7/21, indicated R5 entered R4's room insisting that it was R5's room. R5 and R4 were talking loudly. R5 then became upset with R4 and family member (FM)-A witnessed R5 kick R4 on R4's shin. FM-A was able to intervene until staff was present and took R5 back to R5's room. On 1/6/21, at 12:50 p.m. FM-A stated they did not remember all of the story and "whatever I reported to the social worker is what happened." On 1/6/21, at 2:17 p.m. licensed social worker (LSW) indicated she was made aware of the incident on the morning of 12/14/20, when reviewing progress notes. LSW then reported the incident and began the internal investigation. On 1/6/21, at 2:29 p.m. registered nurse (RN)- A indicated FM-A reported incident to him "in passing" on 12/11/20 but did not witness the incident. Further, RN-A stated the residents were	F 600	residents 5x/week x1 week, then 3x/week x 4weeks, then monthly for three months to ensure no complaints of maltreatment. Director of Nursing or designee will complete audits of interventions that were implemented to prevent further potential abuse daily 5x/week, then 3x/week x 4 weeks, then monthly until QAPI committee determines no longer needed. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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F 600	Continued From page 3 seperated and extra monitoring added to ensure the safety of both residents. On 1/7/21, at 10:12 a.m director of nursing (DON) stated immediate education was provided to RN-A regarding reporting incidents, signs with each resident name in large font was placed on each room at eye level to eliminate the confusion, and extra monitoring was added to ensure safety. Facility policy Maltreatment Prohibition Policy, reviewed 2/19/18, indicated "St. Francis Health Services of Morris (SFHS) has established safeguards to prohibit maltreatment (abuse, neglect, and financial exploitations) of any vulnerable adult in SFHS care center." Further review of facility policy, indicated abuse is the willful infliction of injury and it includes physical abuse. Facility policy defined physical abuse as "occurs when an individual is injured (kicked). In addition, facility policy identified vulnerable adult (VA) to VA abuse as "VA willfully attempting to inflict injury upon another VA. 'willful' means that the individual's action was deliberate (not inadvertent or accidental) regardless of whether the individual intended to inflict injury or harm. Even though a VA may have a cognitive impairment, he/she could still commit a deliberate (willful) act."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		3/12/21

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F 609	Continued From page 4 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of resident to resident abuse to the State Agency within two hours for 2 of 3 residents (R4, R5) reviewed for timely reporting of abuse allegations. Findings include: R4's admission minimal data set (MDS) dated 11/24/20, indicated R4 had diagnoses that included anxiety disorder and hip fracture. Staff also indicated that R4 does have short and long term memory problems with moderately impaired cognitive skills for daily decision making.	F 609	It□s LFHS policy to report alleged violations of abuse, neglect, or mistreatment in a timely manner. Administrator and/or designee will implement corrective action for resident R4 affected by this practice. Administrator and/or designee will implement measures to ensure that this practice does not reoccur. All facility staff will be re-educated on the proper procedure for Maltreatment Reporting including the types of maltreatment or abuse and guidelines for timely reporting. Licensed nurses were re-educated on the importance of notifying the Administrator	

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F 609	Continued From page 5 R4's care plan dated 1/7/21, indicated resident was vulnerable related to cognitive status and physical condition. R5's quarterly MDS dated 10/28/20, indicated R5 had diagnoses that included dementia, anxiety disorder, and depression. R5's progress note dated 12/11/20, indicated "Resident was physically abused by another (R4) accusing her of taking her room. A visitor (family member (FM)-A) in the next room witnessed the incident and reported." Internal investigation report dated 1/7/21, indicated R5 entered R4's room insisting that it was R5's room. R5 and R4 were talking loudly. R5 then became upset with R4 and FM-A witnessed R5 kick R4 on R4's shin. FM-A was able to intervene until staff was present and took R5 back to R5's room. On 1/6/21, at 12:50 p.m. family member (FM)- A indicated on 12/11/20, she witnessed R5 kick R4 and she reported the incident immediately to RN-A on 12/11/20. On 1/6/21, at 2:17 p.m. licensed social worker (LSW) indicated she was made aware of the incident on the morning of 12/14/21, when LSW reviewed progress notes. LSW reported the incident and began the investigation. LSW stated the incident should have been reported "right after it happened". Further, LSW stated everyone is a mandated reporter, and there is a vulnerable adult (VA) reference book but staff are able to contact the director of nursing (DON) or administrator with questions.	F 609	immediately. The Administrator and/or designee will monitor corrective actions to ensure the effectiveness of these actions including Social Services will interview random residents 5x/week x1 week, then 3x/week x 4weeks, then monthly until QAPI committee determines no longer needed. Administrator will monitor corrective actions by completing random audits on allegations of maltreatment of a vulnerable adult that were reported to the State Agency to ensure they were reported timely. Audits will be completed daily x 1 week, 3x/week x 4weeks, then monthly x then monthly until QAPI committee determines no longer needed. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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On 1/6/21, at 2:29 p.m. registered nurse (RN)-A confirmed he wrote the progress note in R5's record dated 12/11/20. RN-A indicated he was notified of the incident "in passing" on 12/11/20, by family member (FM)-A who witnessed R5 kick R4. Further, RN stated that the report he received was not that R5 kicked R4, at that time it was a verbal contradiction. However, progress note dated 12/11/20,written by RN-A, does use the verbiage of physically abused. RN-A stated they were going to email the DON due to it being well past business hours. However, RN-A stated "most definitely should have reported soon after, but I don't know the time frame for reporting abuse." RN-A indicated the facility had trained RN-A on reporting abuse and there is a template in the VA book to follow. RN-A stated they would report physical, financial, sexual abuse, and neglect within "48 hours or its 12 hours, I am not sure."

On 1/7/21, at 10:12 a.m. DON stated the incident occurred on 12/11/20, but she was not made aware of incident until 12/14/20. DON indicated all licensed nursing staff have access for making the initial report to the SA. Further, DON stated this incident should have been reported "that evening" and this incident would have needed to be reported within 24 hours due to no injury.

On 1/7/21, at 10:56 a.m. Administrator indicated the incident occurred on 12/11/20, around 4:00 p.m. and was made aware of incident on 12/14/20. Further, Administrator indicated licensed nurses are trained on initial reporting. Administrator stated staff were expected to report abuse "per facility policy and use our VA book to determine when something should be reported to me, DON, or the state." However, when asked

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	245399	A. BUILDING _____ B. WING _____	C 01/12/2021

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 609	Continued From page 7	F 609		

about when incident should have been reported, Administrator stated "abuse is to be reported immediately. Abuse is a willful infliction of injury with resulting physical harm pain or mental anguish, but because there was no harm to the resident I don't believe it [the incident] would fall into the category of abuse."

On 1/7/21, at 11:16 a.m. registered nurse (RN)-B stated they were made aware of the incident on 12/14/20, and then notified DON. Further, RN-B indicated they would report "anything that warrants a VA, like physical or verbal and things of that matter would report immediately. This incident should have been reported upon the moment of the incident."

On 1/7/21, at 11:55 a.m. DON confirmed abuse should be reported "immediately if there is an injury, it's two hours, if there is no injury 24 hours. This incident should have been reported within 24 hours since there was no injury."

On 1/7/21, at 12:10 p.m. licensed practical nurse (LPN)-A indicated on 12/12/20, when report was given at the beginning of shift it was reported that there was an altercation between R5 and R4, however was not notified if it had already been reported. Further, LPN-A stated "our protocol is whoever sees it or is on shift should report it to the nurse that is there" and would report immediately if any signs of physical abuse.

Facility policy Maltreatment Prohibition Policy dated 2/19/18, defines immediately as "soon as possible, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily

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F 609	Continued From page 8 injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." Facility policy Training Employees on Maltreatment Prohibition Policy dated 2/19/18, indicated "staff will be instructed on the reporting mechanism for this care center. Staff are informed that they are considered 'mandated reporters' if they should observe any one mistreating a VA in any of the ways that are definition is considered 'abuse' or 'neglect.'"	F 609		
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 - §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 implement care plan interventions to prevent the likelihood of potential falls for 2 of 3 (R4 and R7) residents. Findings include: R7's facesheet undated, identified diagnosis of Alzheimer disease, delusional disorders, hallucinations, major depressive disorders, previous hip fracture. R7's minimum data set dated 9/17/20, identified	F 689	It is LFHS policy to ensure that Residents are free from Hazards/Supervision/Devices and residents environment remains as free of accidents hazards as possible. Facility Fall Prevention and Management policy was reviewed by DON. On 1/12/21 R7 had Grip Strips placed on the floor by her bed and in her bathroom. On 1/12/21 R7 had bilateral grab bars placed on bed. On 1/12/21 R4 had anti-slip materiel replaced under her fall mat.	3/12/21

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F 689	Continued From page 9 severe cognitive impairment. R7 requires extensive with transfers and bed mobility. R7's Care plan revised 11/12/20, indicated at risk for falls or injury related to cognitive deficits with interventions of non skid strips on floor by bed and toilet, foot pedals to be used during wheelchair mobility provided by staff. During observation on 1/11/21, at 1:10 p.m. R7's floor in bedroom and bathroom had no anti slip stickers on the floor by the bed or by the toilet. R7's bed was pushed against the wall with only one bed rail on bed on the side opposite of the wall. During interview on 1/11/21, at 1:16 p.m. nursing assistant (NA)-A stated R7 is a falls risk and is to have bed in low position with the mat on the floor. NA-A stated she doesn't believe that R7 has the anti skid strips on the floor. During interview on 1/11/21, at 1:43 p.m. NA-B stated R7 was to have anti skid strips on the floor incase she would try to stand up since she has dementia and is a falls risk. During interview on 1/11/21, at 2:32 p.m. NA-C stated R7 is a falls risk and according to her care plan that indicates non skid grips to be on floor by bed and bathroom and stated they appear to be missing. NA-C further stated with looking at her care plan that it shows she should have 2 bed rails on her bed and it only has one. NA-C stated that they interventions are put in place to help with reposition of resident and to prevent falls. NA-C stated that if these are missing they would notify the nurse, charge nurse or maintenance so they could put these back in place.	F 689	On 1/14/21, Facility implemented a room-move email checklist to ensure care plan interventions are put into place when residents move rooms. On 2/9/21 Nursing staff were re-educated on the importance of following the residents care plan/ NAR group sheet assignments. Director of Nursing and/or designee will complete random audits on care plan interventions in relation to falls 5x/week x 1 week, 3x/week x 4weeks, and weekly until QAPI committee determines no longer needed. Director of Nursing and/or designee will correct issues identified through audits, including adding interventions and training staff as needed. Audits will be brought to the next QAPI meeting to be evaluated for effectiveness.	

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F 689	Continued From page 10	F 689		

During observation on 1/12/21, at 6:55 a.m. R7 laying in bed with once side rail on bed, no anti skid grips noted on floor next to bed or in bathroom.

During phone interview on 1/12/21, at 9:24 a.m. registered nurse (RN)-A stated that if an intervention is on the care plan she would expect that it is in place. Stated interventions are put in place to prevent R7 from falling. R7 stated that if staff were aware that interventions were not in place she would expect them to notify nurse immediately so the intervention could be put back in place.

During interview on 1/12/21, at 10:10 a.m. Director of Nursing (DON) stated R7 is a falls risk. DON looked at care plan and on care plan stated that she should have two bed rails on bed and anti grip strips on the floor by bed and in bathroom. DON stated she is not sure if these are still current as she has not gotten up by herself in a while and would need to speak with the case manager. DON further stated these interventions are put in place for safety.

R4's facesheet dated 1/7/21, identified diagnosis of Alzheimer's disease.

R4's admission minimum data set (MDS) dated 11/24/20, indicated R4 requires extensive assist of two staff for bed mobility, transfers, toileting and personal hygiene.

R4's care plan dated 1/7/21, indicated at risk for falls or injury related to recent diagnosis of left hip and wrist fracture. Further, care plan indicated interventions consisted of anti-slip material under

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fall mat.

Progress note dated 11/18/20, indicated R4 was found on knees, upper torso on the bed, and two abrasions on knees.

Facility document titled Lindbergh Park-Group A printed on 1/7/21, indicated R4 safety interventions included: low bed, fall mats, bilateral bed rails, roam guard left ankle, anti-roll backs, assess footwear, and fall mats out of reach when not in use. Further, document indicated staff to frequently check R4, care-planned to place self on floor out of bed, and offer naps more frequently, and anti-slip material under fall mats were typed in bold.

During observation on 1/11/21, at 1:56 p.m. R4 was laying in bed, with bed at lowest position with floor mat placed on floor, however there were no anti-slip material under the floor mat.

On 1/11/21, at 2:22 p.m. NA-D stated R4 was considered to be a fall risk. NA-D referenced Lindberg Park-Group A document. When asked about the bolded letters for anti-slip material under mat, NA-D stated it is bolded because it is either the "most important or it is new."

On 1/11/21, at approximately 2:22 p.m. R4 continued to lay in bed. NA-D entered R4's room and lifted up R4's floor mat and stated "they should be under the mat and there is one that goes on each side. We should have checked on rounds but that slipped my mind I won't lie about that. We did not look." Further, NA-D stated she was unable to find the anti-slip material and exited R4's room.

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F 689	Continued From page 12 During continuous observation on 1/11/21, from 2:32 through 3:03 p.m. R4 continued to lay in bed and no anti-slip material was placed under floor mat. On 1/12/21, at 9:16 a.m. RN-B stated R4 was consider a fall risk and majority of R4's falls have been out of bed. RN-B indicated falls interventions are placed on the Lindberg Park document to guide the nursing assistants and "if it is a newer task or if I want it to stick out I will bold it." RN-B confirmed anti-slip material under fall mat was bolded related to R4 had been known to sit on edge of bed and kick the mat away from the bed. Further, RN-B indicated staff were expected to place the material under the fall mat when R4 is in bed for safety and to prevent the mat from slipping if R4 were to slide out of bed or kick the mat. On 1/12/21, at 9:33 a.m. LPN-B identified R4 as a fall risk. LPN-B referenced Lindberg Park document for interventions related to fall risk and indicated anti-slip material was bolded related to it being a new intervention for R4. Further, LPN-B stated it was important for staff to place the material under the mat to "to give more grip to stay in place if she tries to crawl out of bed and that makes her more of a fall risk and if that mat slips she is more opt to fall." On 1/12/21, at 10:15 a.m. DON identified R4 as a fall risk and to prevent further injury anti-slip under the mat was an intervention if R4 does fall or put herself on the floor "we want to protect her and the fall to be as safe as possible." Further, DON indicated staff were expected to check for the anti-slip material and if it was not there to place it under the mat.	F 689		

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F 689	Continued From page 13 Policy Fall prevention and Management dated 10/12/17, indicated "The facility will assess each resident for their fall risk on admission, quarterly and with any significant change in condition and will identify interventions to help prevent falls, and/or prevent injuries from falls. if a fall occurs, staff will conduct a root cause analysis to identify interventions to prevent subsequent falls and/or injury from further falls" "Fall Risk assessment: If a resident's fall risk score is >/= to 9, a comprehensive fall assessment will be completed to identify resident's history of falls, activity level, visual impairment, balance and gait, elimination status and diagnoses and medications, etc. that can contribute to falls. The data gathered will be analyzed. A summary will be completed and interventions will be developed and implemented to mitigate the resident's fall risk."	F 689		

Electronically delivered
February 2, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: ATZJ11

Dear Administrator:

The above facility was surveyed on January 6, 2021 through January 12, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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
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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 1/6/21-1/12/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED:	2 000		

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2 000	Continued From page 1 H5399044C-MN67086 H5399043C-MN68136 H5399045C-MN63100 with an order cited. The following complaint was found to be UNSUBSTANTIATED: H5399046C-MN60152 H5399040C-MN64840 H5399041C-MN62488 H5399042C MN64803 and MN64842 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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		
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 implement care plan	2 830	Corrected	4/12/21

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2 830	Continued From page 2 interventions to prevent the likelihood of potential falls for 2 of 3 (R4 and R7) residents. Findings include: R7's facesheet undated, identified diagnosis of Alzheimer disease, delusional disorders, hallucinations, major depressive disorders, previous hip fracture. R7's minimum data set dated 9/17/20, identified severe cognitive impairment. R7 requires extensive with transfers and bed mobility. R7's Care plan revised 11/12/20, indicated at risk for falls or injury related to cognitive deficits with interventions of non skid strips on floor by bed and toilet, foot pedals to be used during wheelchair mobility provided by staff. During observation on 1/11/21, at 1:10 p.m. R7's floor in bedroom and bathroom had no anti slip stickers on the floor by the bed or by the toilet. R7's bed was pushed against the wall with only one bed rail on bed on the side opposite of the wall. During interview on 1/11/21, at 1:16 p.m. nursing assistant (NA)-A stated R7 is a falls risk and is to have bed in low position with the mat on the floor. NA-A stated she doesn't believe that R7 has the anti skid strips on the floor. During interview on 1/11/21, at 1:43 p.m. NA-B stated R7 was to have anti skid strips on the floor incase she would try to stand up since she has dementia and is a falls risk. During interview on 1/11/21, at 2:32 p.m. NA-C stated R7 is a falls risk and according to her care	2 830		

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2 830	Continued From page 3 plan that indicates non skid grips to be on floor by bed and bathroom and stated they appear to be missing. NA-C further stated with looking at her care plan that it shows she should have 2 bed rails on her bed and it only has one. NA-C stated that they interventions are put in place to help with reposition of resident and to prevent falls. NA-C stated that if these are missing they would notify the nurse, charge nurse or maintenance so they could put these back in place. During observation on 1/12/21, at 6:55 a.m. R7 laying in bed with once side rail on bed, no anti skid grips noted on floor next to bed or in bathroom. During phone interview on 1/12/21, at 9:24 a.m. registered nurse (RN)-A stated that if an intervention is on the care plan she would expect that it is in place. Stated interventions are put in place to prevent R7 from falling. R7 stated that if staff were aware that interventions were not in place she would expect them to notify nurse immediately so the intervention could be put back in place. During interview on 1/12/21, at 10:10 a.m. Director of Nursing (DON) stated R7 is a falls risk. DON looked at care plan and on care plan stated that she should have two bed rails on bed and anti grip strips on the floor by bed and in bathroom. DON stated she is not sure if these are still current as she has not gotten up by herself in a while and would need to speak with the case manager. DON further stated these interventions are put in place for safety. R4's facesheet dated 1/7/21, identified diagnosis of Alzheimer's disease.	2 830		

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 01/12/2021

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2 830	Continued From page 4 R4's admission minimum data set (MDS) dated 11/24/20, indicated R4 requires extensive assist of two staff for bed mobility, transfers, toileting and personal hygiene. R4's care plan dated 1/7/21, indicated at risk for falls or injury related to recent diagnosis of left hip and wrist fracture. Further, care plan indicated interventions consisted of anti-slip material under fall mat. Progress note dated 11/18/20, indicated R4 was found on knees, upper torso on the bed, and two abrasions on knees. Facility document titled Lindbergh Park-Group A printed on 1/7/21, indicated R4 safety interventions included: low bed, fall mats, bilateral bed rails, roam guard left ankle, anti-roll backs, assess footwear, and fall mats out of reach when not in use. Further, document indicated staff to frequently check R4, care-planned to place self on floor out of bed, and offer naps more frequently, and anti-slip material under fall mats were typed in bold. During observation on 1/11/21, at 1:56 p.m. R4 was laying in bed, with bed at lowest position with floor mat placed on floor, however there were no anti-slip material under the floor mat. On 1/11/21, at 2:22 p.m. NA-D stated R4 was considered to be a fall risk. NA-D referenced Lindberg Park-Group A document. When asked about the bolded letters for anti-slip material under mat, NA-D stated it is bolded because it is either the "most important or it is new." On 1/11/21, at approximately 2:22 p.m. R4 continued to lay in bed. NA-D entered R4's room	2 830		

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2 830	Continued From page 5 and lifted up R4's floor mat and stated "they should be under the mat and there is one that goes on each side. We should have checked on rounds but that slipped my mind I won't lie about that. We did not look." Further, NA-D stated she was unable to find the anti-slip material and exited R4's room. During continuous observation on 1/11/21, from 2:32 through 3:03 p.m. R4 continued to lay in bed and no anti-slip material was placed under floor mat. On 1/12/21, at 9:16 a.m. RN-B stated R4 was consider a fall risk and majority of R4's falls have been out of bed. RN-B indicated falls interventions are placed on the Lindberg Park document to guide the nursing assistants and "if it is a newer task or if I want it to stick out I will bold it." RN-B confirmed anti-slip material under fall mat was bolded related to R4 had been known to sit on edge of bed and kick the mat away from the bed. Further, RN-B indicated staff were expected to place the material under the fall mat when R4 is in bed for safety and to prevent the mat from slipping if R4 were to slide out of bed or kick the mat. On 1/12/21, at 9:33 a.m. LPN-B identified R4 as a fall risk. LPN-B referenced Lindberg Park document for interventions related to fall risk and indicated anti-slip material was bolded related to it being a new intervention for R4. Further, LPN-B stated it was important for staff to place the material under the mat to "to give more grip to stay in place if she tries to crawl out of bed and that makes her more of a fall risk and if that mat slips she is more opt to fall." On 1/12/21, at 10:15 a.m. DON identified R4 as a fall risk and to prevent further injury anti-slip	2 830		

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2 830	Continued From page 6 under the mat was an intervention if R4 does fall or put herself on the floor "we want to protect her and the fall to be as safe as possible." Further, DON indicated staff were expected to check for the anti-slip material and if it was not there to place it under the mat. Policy Fall prevention and Management dated 10/12/17, indicated "The facility will assess each resident for their fall risk on admission, quarterly and with any significant change in condition and will identify interventions to help prevent falls, and/or prevent injuries from falls. if a fall occurs, staff will conduct a root cause analysis to identify interventions to prevent subsequent falls and/or injury from further falls" "Fall Risk assessment: If a resident's fall risk score is >/= to 9, a comprehensive fall assessment will be completed to identify resident's history of falls, activity level, visual impairment, balance and gait, elimination status and diagnoses and medications, etc. that can contribute to falls. The data gathered will be analyzed. A summary will be completed and interventions will be developed and implemented to mitigate the resident's fall risk." Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessaryservices to prevent or improve areas from occuring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		