

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 Therefore, the NATCEP prohibition is rescinded.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,

Durentes Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Little Falls Care Center April 9, 2021 Page 2 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



Protecting, Maintaining and Improving the Health of All Minnesotans

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.

Little Falls Care Center March 22, 2021 Page 2

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

Little Falls Care Center March 22, 2021 Page 3

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Doverto Stapson

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Davene Stapson

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

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	`´co∧	E SURVEY IPLETED
		245399	B. WING	i			C 12/2021
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		_			1200 FIRST AVENUE NORTHEAST		
	ALLS CARE CENTER	K		L	LITTLE FALLS, MN 56345		
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	Revised 2567 as a Assurance review.	result of a MDH's Quality					
	was completed at y complaint investiga NOT to be in comp	1/12/21, an abbreviated survey our facility to conduct a tion. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.					
	SUBSTANTIATED: H5399044C-MN67 H5399043C-MN68	086					
	As a result of the in were also identified	vestigations other deficiencies at F609.					
	The following comp UNSUBSTANTIAT H5399046C-MN60 H5399040C-MN64 H5399041C-MN62 H5399042C MN64	152 840 488					
		f correction (POC) will serve of compliance upon the ptance.					
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	ically 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.

PRINTED: 03/02/2021

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA). 0938-039 TE SURVEY MPLETED
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	must:	n, or mistreatment, the facility are that all alleged violations				
	involving abuse, ne mistreatment, inclu	eglect, exploitation or iding injuries of unknown propriation of resident property,				
	are reported imme hours after the alle that cause the alle	diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if				
	the events that cau abuse and do not r the administrator o officials (including t and adult protective provides for jurisdie	ise the allegation do not involve esult in serious bodily injury, to f the facility and to other to the State Survey Agency e services where state law ction in long-term care ance with State law through				
	designated represe accordance with St Survey Agency, wit incident, and if the appropriate correct	ort the results of all e administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced				

Facility ID: 00382

If continuation sheet Page 2 of 11

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	facility failed to reportesident abuse to the hours for 2 of 3 restimely reporting of a Findings include: R4's admission min 11/24/20, indicated included anxiety disalso indicated that term memory problecognitive skills for or R4's care plan date was vulnerable relations was vulnerable relations. R5's quarterly MDS had diagnoses that disorder, and depresent the disorder of tak member (FM)-A) in incident and reported indicated R5 entered was R5's room. R5 R5 then became up witnessed R5 kick	nimal data set (MDS) dated R4 had diagnoses that sorder and hip fracture. Staff R4 does have short and long lems with moderately impaired daily decision making. ed 1/7/21, indicated resident ated to cognitive status and S dated 10/28/20, indicated R5 t included dementia, anxiety ession. e dated 12/11/20, indicated sically abused by another (R4) ing her room. A visitor (family the next room witnessed the		It □s LFHS policy to report violations of abuse, neglect mistreatment in a timely ma Administrator and/or design implement corrective action R4 affected by this practice Administrator and/or design implement measures to ens practice does not reoccur. A will be re-educated on the p procedure for Maltreatment including the types of maltre abuse and guidelines for tin Licensed nurses were re-ed importance of notifying the immediately. The Administr designee will monitor correct ensure the effectiveness of including Social Services w random residents 5x/week 3x/week x 4weeks, then mo QAPI committee determine needed. Administrator will r corrective actions by compl audits on allegations of mal vulnerable adult that were r State Agency to ensure the reported timely. Audits will I daily x 1 week, 3x/week x 4 monthly x then monthly unt committee determines no lo Audit results will be brough committee quarterly for rev recommendation.	a, or anner. hee will for resident for resident rese will sure that this All facility staff proper Reporting eatment or nely reporting. ducated on the Administrator rator and/or ctive actions to these actions ill interview x1 week, then ponthly until s no longer nonitor eting random treatment of a eported to the y were be completed weeks, then il QAPI onger needed. t to the QAPI	

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F 609	RN-A on 12/11/20. On 1/6/21, at 2:17 p (LSW) indicated sh incident on the mor reviewed progress i incident and began the incident should after it happened". I is a mandated repo adult (VA) reference contact the director administrator with q On 1/6/21, at 2:29 p confirmed he wrote record dated 12/11/ notified of the incide by family member (R4. Further, RN sta was not that R5 kic verbal contradiction dated 12/11/20,writ verbiage of physica were going to email past business hours "most definitely sho but I don't know the abuse." RN-A indica RN-A on reporting a in the VA book to for report physical, fina	be incident immediately to b.m. licensed social worker e was made aware of the ning of 12/14/21, when LSW notes. LSW reported the the investigation. LSW stated have been reported "right Further, LSW stated everyone orter, and there is a vulnerable e book but staff are able to of nursing (DON) or	F	609			
	occurred on 12/11/2	a.m. DON stated the incident 20, but she was not made ntil 12/14/20. DON indicated					

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		AND HUMAN SERVICES				FORM	03/02/2021 APPROVED 0938-0391
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F 609	all licensed nursing	staff have access for making	F6	609			
	this incident should evening" and this in	the SA. Further, DON stated have been reported "that noident would have needed to 24 hours due to no injury.					
	the incident occurre p.m. and was made 12/14/20. Further, A licensed nurses are Administrator states abuse "per facility p determine when so me, DON, or the sta about when inciden Administrator states immediately. Abuse with resulting physic anguish, but becau	a.m. Administrator indicated ed on 12/11/20, around 4:00 e aware of incident on Administrator indicated e trained on initial reporting. d staff were expected to report policy and use our VA book to mething should be reported to ate." However, when asked at should have been reported, d "abuse is to be reported e is a willful infliction of injury cal harm pain or mental se there was no harm to the					
	into the category of On 1/7/21, at 11:16 stated they were m 12/14/20, and then indicated they woul warrants a VA, like of that matter would incident should hav moment of the incid On 1/7/21, at 11:55 should be reported injury, it's two hours This incident should hours since there w	6 a.m. registered nurse (RN)-B ade aware of the incident on notified DON. Further, RN-B d report "anything that physical or verbal and things d report immediately. This re been reported upon the dent." 6 a.m. DON confirmed abuse "immediately if there is an s, if there is no injury 24 hours. d have been reported within 24					

Facility ID: 00382

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		I AND HUMAN SERVICES				FORM	03/02/2021 APPROVED 0938-0391
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 (LPN)- given a there w howew reports whoey the nu immed Facility dated possib allegat allegat allegat allegat injury, cause not res Facility Maltre indicat mecha inform reports mistre definiti F 689 Free o SS=D CFR(s §483.2 The fa §483.2 as free 	at the beginni was an alterci- rer was not no ed. Further, L rer sees it or i rse that is the diately if any s y policy Maltre 2/19/18, defir ble, but not lat tion is made, tion involve al or not later th the allegation sult in serious y policy Traini atment Prohi ted "staff will anism for this ed that they a ers' if they shi ating a VA in ion is conside of Accident Ha s): 483.25(d)(25(d) Accident 25(d)(2)Each vision and as	on 12/12/20, when report was ing of shift it was reported that ation between R5 and R4, ptified if it had already been PN-A stated "our protocol is is on shift should report it to ere" and would report signs of physical abuse. eatment Prohibition Policy hes immediately as "soon as ther than 2 hours after the if the events that cause the buse or result in serious bodily han 24 hours if the events that in do not involve abuse and do a bodily injury." ing Employees on bition Policy dated 2/19/18, be instructed on the reporting care center. Staff are are considered 'mandated ould observe any one any of the ways that are ered 'abuse' or 'neglect.'" azards/Supervision/Devices 1)(2)	Fé	609			4/12/21

Facility ID: 00382

If continuation sheet Page 6 of 11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY PLETED
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LITTLE F	ALLS CARE CENTE	R		1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 689	by: Based on observa review the facility fa interventions to pre- falls for 2 of 3 (R4 Findings include: R7's facesheet und Alzheimer disease hallucinations, maj previous hip fractu R7's minimum data severe cognitive in extensive with tran R7's Care plan rev for falls or injury re- interventions of no and toilet, foot ped wheelchair mobility During observation floor in bedroom an stickers on the floo R7's bed was push one bed rail on bed wall. During interview or assistant (NA)-A st have bed in low po	NT is not met as evidenced ation, interview, and document ailed to implement care plan event the likelihood of potential and R7) residents. dated, identified diagnosis of , delusional disorders, for depressive disorders, re. a set dated 9/17/20, identified npairment. R7 requires isfers and bed mobility. rised 11/12/20, indicated at risk lated to cognitive deficits with n skid strips on floor by bed als to be used during	F 68	It is LFHS policy to ensure that R are free from Hazards/Supervision/Devices and residents □ environment remains of accidents hazards as possible. Fall Prevention and Management was reviewed by DON. On 1/12/21 R7 had Grip Strips pla the floor by her bed and in her ba On 1/12/21 R7 had bilateral grab placed on bed. On 1/12/21 R4 ha anti-slip materiel replaced under f mat. On 1/14/21, Facility implemented room-move email checklist to ens plan interventions are put into pla residents move rooms. On 2/9/21 Nursing staff were re-e on the importance of following the residents⊡ care plan/ NAR group assignments. Director of Nursing and/or design complete random audits on care µ interventions in relation to falls 5x 1 week, 3x/week x 4weeks, and v until QAPI committee determines longer needed. Director of Nursin designee will correct issues identit through audits, including adding interventions and training staff as Audits will be brought to the next meeting to be evaluated for effect	I as free Facility policy aced on throom. bars d are fall a gure care ce when ducated sheet ee will blan /week x veekly no g and/or fied needed. QAPI	

If continuation sheet Page 7 of 11

		I AND HUMAN SERVICES				FORM	: 03/02/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245399	B. WING				C 12/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	ALLS CARE CENTER	र			1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	dementia and is a falled During interview on stated R7 is a falled plan that indicates r bed and bathroom a missing. NA-C furth care plan that it sho rails on her bed and that they intervention with reposition of re NA-C stated that if the notify the nurse, chat they could put these During observation laying in bed with out skid grips noted on bathroom. During phone interver registered nurse (R intervention is on the that it is in place. St place to prevent R7 staff were aware that place she would ext immediately so the in place. During interview on Director of Nursing risk. DON looked at stated that she sho and anti grip strips of bathroom. DON stated	y to stand up since she has alls risk. 1/11/21, at 2:32 p.m. NA-C risk and according to her care non skid grips to be on floor by and stated they appear to be her stated with looking at her ows she should have 2 bed d it only has one. NA-C stated ons are put in place to help esident and to prevent falls. these are missing they would arge nurse or maintenance so e back in place. on 1/12/21, at 6:55 a.m. R7 nce side rail on bed, no anti floor next to bed or in <i>v</i> iew on 1/12/21, at 9:24 a.m. N)-A stated that if an he care plan she would expect tated interventions are put in 7 from falling. R7 stated that if at interventions were not in pect them to notify nurse intervention could be put back 1/12/21, at 10:10 a.m. (DON) stated R7 is a falls t care plan and on care plan uld have two bed rails on bed on the floor by bed and in ated she is not sure if these are	F	589			
	still current as she h	ated she is not sure if these are has not gotten up by herself in need to speak with the case					

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		I AND HUMAN SERVICES				FORM	03/02/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245399	B. WING	i			C 12/2021
NAME OF F	PROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
	ALLS CARE CENTER	٢			1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	are put in place for R4's facesheet date of Alzheimer's disea R4's admission min 11/24/20, indicated of two staff for bed and personal hygied R4's care plan date falls or injury related and wrist fracture. F interventions consis fall mat. Progress note date found on knees, up abrasions on knees Facility document ti printed on 1/7/21, ir interventions includ bed rails, roam gua assess footwear, ar not in use. Further, frequently check R4 on floor out of bed, frequently, and anti- were typed in bold. During observation was laying in bed, v floor mat placed on anti-slip material un On 1/11/21, at 2:22	her stated these interventions safety. ed 1/7/21, identified diagnosis ase. himum data set (MDS) dated R4 requires extensive assist mobility, transfers, toileting ne. ed 1/7/21, indicated at risk for d to recent diagnosis of left hip Further, care plan indicated sted of anti-slip material under d 11/18/20, indicated R4 was per torso on the bed, and two s. tled Lindbergh Park-Group A hdicated R4 safety led: low bed, fall mats, bilateral ird left ankle, anti-roll backs, nd fall mats out of reach when document indicated staff to 4, care-planned to place self and offer naps more -slip material under fall mats on 1/11/21, at 1:56 p.m. R4 with bed at lowest position with floor, however there were no nder the floor mat.	F	589			
		p.m. NA-D stated R4 was fall risk. NA-D referenced					

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		I AND HUMAN SERVICES				FORM	03/02/2021 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245399	B. WING	i			C 12/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LITTLE F	FALLS CARE CENTER	र			1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Lindberg Park-Grou about the bolded le under mat, NA-D st either the "most imp On 1/11/21, at appr continued to lay in t and lifted up R4's fl should be under the goes on each side. rounds but that slip that. We did not loo was unable to find t exited R4's room. During continuous of 2:32 through 3:03 p and no anti-slip ma mat. On 1/12/21, at 9:16 consider a fall risk a been out of bed. RN interventions are pl document to guide is a newer task or it it." RN-B confirmed mat was bolded rela- sit on edge of bed a the bed. Further, R expected to place the when R4 is in bed f mat from slipping if kick the mat. On 1/12/21, at 9:33 fall risk. LPN-B refer document for interv- indicated anti-slip n	up A document. When asked tters for anti-slip material tated it is bolded because it is portant or it is new." roximately 2:22 p.m. R4 bed. NA-D entered R4's room oor mat and stated "they e mat and there is one that We should have checked on ped my mind I won't lie about ok." Further, NA-D stated she the anti-slip material and observation on 1/11/21, from o.m. R4 continued to lay in bed terial was placed under floor	F	689			

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		I AND HUMAN SERVICES				FORM	03/02/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245399	B. WING				C 12/2021
NAME OF PROVIDER OR SU	JPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LITTLE FALLS CARE	CENTER	र			200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
PREFIX (EACH DE	FICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
material und stay in place that makes slips she is a On 1/12/21, fall risk and under the m or put herse and the fall to DON indicat the anti-slip place it unde Policy Fall p 10/12/17, in resident for and with any will identify i and/or preve staff will cor interventions to identify re visual impai status and oc can contribu analyzed. A interventions	s import ler the re- e if she her more op at 10:1 to prev at was lf on the to be as red staf materia er the n reventid dicated their fai y signifi nterven ent injur duct a s to pre urther f fall risk sive fall sident's rment, l liagnos at to fa s will be	tant for staff to place the mat to "to give more grip to tries to crawl out of bed and re of a fall risk and if that mat ot to fall." 5 a.m. DON identified R4 as a ent further injury anti-slip an intervention if R4 does fall e floor "we want to protect her s safe as possible." Further, f were expected to check for al and if it was not there to	F	\$89			

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			ľ		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-			MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	Сом	E SURVEY IPLETED
		245399	B. WING	i			C 12/2021
NAME OF F	PROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	ALLS CARE CENTER	۶			1200 FIRST AVENUE NORTHEAST		
					LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F(000)		
	Revised 2567 as a Assurance review.	result of a MDH's Quality					
	was completed at y complaint investiga NOT to be in comp	1/12/21, an abbreviated survey our facility to conduct a tion. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.					
	SUBSTANTIATED: H5399044C-MN670 H5399043C-MN68	086					
	As a result of the in were also identified	vestigations other deficiencies at F609.					
	The following comp UNSUBSTANTIATE H5399046C-MN60 H5399040C-MN644 H5399041C-MN624 H5399042C MN648	152 840 488					
		f correction (POC) will serve of compliance upon the ptance.					
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.					
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
	ically 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.

PRINTED: 04/01/2021

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		0938-039 E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		G	· /	PLETED	
					0	0	
		245399	B. WING		01/	12/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LITTLE F	ALLS CARE CENTER	R	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 000	Continued From pa	ae 1	F 000	0			
	· ·	acceptable electronic POC, an		-			
		ur facility may be conducted to					
		ntial compliance with the an attained in accordance with					
	your verification.						
F 600 SS=D	Free from Abuse ar CFR(s): 483.12(a)(0	F 600	0		4/12/21	
	Exploitation The resident has th neglect, misapprop and exploitation as includes but is not I corporal punishmer	rom Abuse, Neglect, and e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to medical symptoms.					
	§483.12(a) The fac	ility must-					
	physical abuse, cor involuntary seclusio	use verbal, mental, sexual, or poral punishment, or on; NT is not met as evidenced					
	Based on interview facility failed to ens	v and document review, the ure residents were free from 3 residents, when R5 was 4's shin.		It is LFHS policy to keep residents from abuse, neglect, and exploitation Director of Nursing and/or designed implement corrective action for res R4, affected by this practice. A pho	on. e will ident		
	Findings include:			R4 and R5 have been placed at ey on their respective door frames as	e level		
	11/24/20, indicated included anxiety dis also indicated that I	imal data set (MDS) dated R4 had diagnoses that sorder and hip fracture. Staff R4 does have short and long em with moderately impaired		intervention to assist residents in determining which room belongs to Director of Nursing and/or designed monitor corrective actions to ensur effectiveness of these actions inclu	e will e the		

Facility ID: 00382

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		AND HUMAN SERVICES				FORM	04/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		245399	B. WING _				C 12/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	FALLS CARE CENTER	2			200 FIRST AVENUE NORTHEAST TTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From pa	ige 2	F 60	00			
		ed 1/7/21, indicated resident ated to cognitive status and			residents 5x/week x1 week, then 3> x 4weeks, then monthly for three m to ensure no complaints of maltreat Director of Nursing or designee will complete audits of interventions that	onths tment.	
		dated 10/28/20, indicated R5 included dementia, anxiety ession.			implemented to prevent further pote abuse daily 5x/week, then 3x/week weeks, then monthly until QAPI committee determines no longer ne	ential x 4	
	"Resident was physicaccusing her of taking member (FM)-A) in incident and reporter and investigation re	dated 12/11/20, indicated sically abused by another (R4) ing her room. A visitor (family the next room witnessed the ed." However, per interviews eport, R5 was the alleged as witnessed to kick R4.			Audit results will be brought to the c committee quarterly for review and recommendation.		
	indicated R5 entere was R5's room. R5 R5 then became up member (FM)-A wit shin. FM-A was able	on report dated 1/7/21, ed R4's room insisting that it and R4 were talking loudly. oset with R4 and family tnessed R5 kick R4 on R4's e to intervene until staff was 5 back to R5's room.					
	remember all of the	p.m. FM-A stated they did not story and "whatever I ial worker is what happened."					
	(LSW) indicated sh incident on the mor reviewing progress	o.m. licensed social worker e was made aware of the rning of 12/14/20, when notes. LSW then reported the the internal investigation.					
	indicated FM-A report passing" on 12/11/2	o.m. registered nurse (RN)- A orted incident to him "in 20 but did not witness the N-A stated the residents were					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/01/2021 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED C		
		245399	B. WING				
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
LITTLE F	ALLS CARE CENTER	R	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	Continued From pa	-	F 60	0			
	the safety of both re	a monitoring added to ensure esidents.					
	stated immediate e RN-A regarding rep each resident name each room at eye le	a.m director of nursing (DON) ducation was provided to orting incidents, signs with e in large font was placed on evel to eliminate the confusion, g was added to ensure safety.					
F 609	reviewed 2/19/18, in Services of Morris (safeguards to prohi neglect, and financi vulnerable adult in s review of facility poli willful infliction of in abuse. Facility polic "occurs when an in addition, facility polic (VA) to VA abuse as inflict injury upon ar the individual's action inadvertent or accion the individual intend Even though a VA r impairment, he/she (willful) act."	eatment Prohibition Policy, ndicated "St. Francis Health (SFHS) has established bit maltreatment (abuse, al exploitations) of any SFHS care center." Further licy, indicated abuse is the jury and it includes physical by defined physical abuse as dividual is injured (kicked). In the yidentified vulnerable adult is "VA willfully attempting to nother VA. 'willful' means that on was deliberate (not lental) regardless of whether ded to inflict injury or harm. may have a cognitive could still commit a deliberate	F 60	10		3/12/21	
SS=D	CFR(s): 483.12(c)(§483.12(c) In respo		1 00				
		re that all alleged violations glect, exploitation or					

Facility ID: 00382

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		& MEDICAID SERVICES				. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY	
			A. BUILDI	NG		С	
		245399	B. WING			01/12/2021	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
		_		1200 FIRST AVENUE NORTHEAST			
	ALLS CARE CENTER	X	LITTLE FALLS, MN 56345				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 609	Continued From no		БС				
F 009	Continued From pa	-	F 60	19			
		ding injuries of unknown propriation of resident property,					
		diately, but not later than 2					
	•	gation is made, if the events					
		gation involve abuse or result in					
		y, or not later than 24 hours if					
		se the allegation do not involve					
		esult in serious bodily injury, to					
		f the facility and to other					
		to the State Survey Agency and					
		vices where state law provides					
		ng-term care facilities) in ate law through established					
	procedures.	ate law through established					
	•						
	§483.12(c)(4) Repo						
		e administrator or his or her					
		entative and to other officials in ate law, including to the State					
		hin 5 working days of the					
		alleged violation is verified					
		ive action must be taken.					
		NT is not met as evidenced					
	by:						
	Based on interview	v and document review, the		It⊡s LFHS policy to report a	alleged		
		ort an allegation of resident to		violations of abuse, neglect,			
		he State Agency within two		mistreatment in a timely ma			
		idents (R4, R5) reviewed for		Administrator and/or design			
	timely reporting of a	abuse allegations.		implement corrective action R4 affected by this practice.	ior resident		
	Findings include:			Administrator and/or design	ee will		
	. mango moludo.			implement measures to ens			
	R4's admission mir	nimal data set (MDS) dated		practice does not reoccur. A			
		R4 had diagnoses that		will be re-educated on the p			
		sorder and hip fracture. Staff		procedure for Maltreatment			
		R4 does have short and long		including the types of maltre			
		ems with moderately impaired		abuse and guidelines for tim			
	cognitive skills for o	daily decision making.		Licensed nurses were re-ed			
				importance of notifying the A	aministrator	1	

Facility ID: 00382

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATI	0938-039 SURVEY PLETED	
				3		C	
		245399	B. WING		01/12/2021		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	S, CITY, STATE, ZIP CODE		
	ALLS CARE CENTE	र		1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 609		age 5 ed 1/7/21, indicated resident ated to cognitive status and	F 609	9 immediately. The Administrator designee will monitor corrective ensure the effectiveness of the	e actions to		
	R5's quarterly MDS	6 dated 10/28/20, indicated R5 : included dementia, anxiety ession.		including Social Services will in random residents 5x/week x1 v 3x/week x 4weeks, then month QAPI committee determines no	terview veek, then ly until o longer		
	"Resident was physical accusing her of tak	dated 12/11/20, indicated sically abused by another (R4) ing her room. A visitor (family the next room witnessed the ed."		needed. Administrator will mon corrective actions by completin audits on allegations of maltrea vulnerable adult that were repo State Agency to ensure they we reported timely. Audits will be c	g random tment of a rted to the ere ompleted		
	indicated R5 entered was R5's room. R5 R5 then became up witnessed R5 kick	on report dated 1/7/21, ed R4's room insisting that it and R4 were talking loudly. oset with R4 and FM-A R4 on R4's shin. FM-A was ntil staff was present and took om.		daily x 1 week, 3x/week x 4wee monthly x then monthly until Q/ committee determines no longe Audit results will be brought to committee quarterly for review recommendation.	API er needed. he QAPI		
	indicated on 12/11/) p.m. family member (FM)- A 20, she witnessed R5 kick R4 ne incident immediately to					
	(LSW) indicated sh incident on the more reviewed progress incident and began the incident should after it happened". is a mandated repo- adult (VA) reference	p.m. licensed social worker he was made aware of the rning of 12/14/21, when LSW notes. LSW reported the the investigation. LSW stated have been reported "right Further, LSW stated everyone orter, and there is a vulnerable e book but staff are able to r of nursing (DON) or					

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		AND HUMAN SERVICES				FORM	04/01/2021 APPROVED 0938-0391		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245399	B. WING	i		C 01/12/2021			
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
	FALLS CARE CENTER	٤	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE		
F 609	On 1/6/21, at 2:29 p confirmed he wrote record dated 12/11/ notified of the incide by family member (R4. Further, RN sta was not that R5 kic verbal contradiction dated 12/11/20,writ verbiage of physica were going to emai past business hour "most definitely sho but I don't know the abuse." RN-A indica RN-A on reporting a in the VA book to for report physical, fina neglect within "48 h sure." On 1/7/21, at 10:12 occurred on 12/11/2 aware of incident un all licensed nursing the initial report to t this incident should evening" and this in be reported within 2 On 1/7/21, at 10:56 the incident occurre p.m. and was made 12/14/20. Further, A licensed nurses are Administrator stated abuse "per facility p determine when so	age 6 o.m. registered nurse (RN)-A e the progress note in R5's (20. RN-A indicated he was ent "in passing" on 12/11/20, FM)-A who witnessed R5 kick ated that the report he received ked R4, at that time it was a n. However, progress note ten by RN-A, does use the illy abused. RN-A stated they I the DON due to it being well s. However, RN-A stated ould have reported soon after, e time frame for reporting ated the facility had trained abuse and there is a template ollow. RN-A stated they would ancial, sexual abuse, and hours or its 12 hours, I am not e a.m. DON stated the incident 20, but she was not made ntil 12/14/20. DON indicated staff have access for making the SA. Further, DON stated have been reported "that ncident would have needed to 24 hours due to no injury. a.m. Administrator indicated e aware of incident on Administrator indicated e trained on initial reporting. d staff were expected to report colicy and use our VA book to mething should be reported to ate." However, when asked	F	609					

Facility ID: 00382

If continuation sheet Page 7 of 14

		AND HUMAN SERVICES				FORM	04/01/2021 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED	
		245399	B. WING	;		C 01/12/2021		
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
LITTLE	FALLS CARE CENTER	ł	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 609	about when inciden Administrator stated immediately. Abuse with resulting physic anguish, but becau resident I don't belia into the category of On 1/7/21, at 11:16 stated they were m 12/14/20, and then indicated they woul warrants a VA, like of that matter would incident should hav moment of the incid On 1/7/21, at 11:55 should be reported injury, it's two hours This incident should hours since there w On 1/7/21, at 12:10 (LPN)-A indicated of given at the beginn there was an alterch however was not no reported. Further, L whoever sees it or the nurse that is the immediately if any s Facility policy Maltro dated 2/19/18, defin possible, but not lat allegation is made,	t should have been reported, d "abuse is to be reported e is a willful infliction of injury cal harm pain or mental se there was no harm to the eve it [the incident] would fall abuse." a.m. registered nurse (RN)-B ade aware of the incident on notified DON. Further, RN-B d report "anything that physical or verbal and things d report immediately. This e been reported upon the dent." a.m. DON confirmed abuse "immediately if there is an s, if there is no injury 24 hours. d have been reported within 24	F	609				

If continuation sheet Page 8 of 14

	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED	
			A. BUILDING	3	C	
		245399	B. WING		01/12/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LITTLE F	ALLS CARE CENTER	2		1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 609	cause the allegation not result in serious	han 24 hours if the events that n do not involve abuse and do bodily injury."	F 609	9		
F 689 SS=D	indicated "staff will mechanism for this informed that they a reporters' if they sh mistreating a VA in definition is conside Free of Accident Ha	bition Policy dated 2/19/18, be instructed on the reporting care center. Staff are are considered 'mandated ould observe any one any of the ways that are ered 'abuse' or 'neglect.''' azards/Supervision/Devices	F 689	9	3/12/21	
	supervision and ass accidents. This REQUIREMEN	resident receives adequate sistance devices to prevent NT is not met as evidenced				
	review the facility fa	tion, interview, and document ailed to implement care plan vent the likelihood of potential and R7) residents.		It is LFHS policy to ensure that Reside are free from Hazards/Supervision/Devices and residents environment remains as fre of accidents hazards as possible. Facili	e	
	Findings include:			Fall Prevention and Management policy was reviewed by DON.	/	
	Alzheimer disease,	ated, identified diagnosis of delusional disorders, or depressive disorders, re.		On 1/12/21 R7 had Grip Strips placed of the floor by her bed and in her bathroor On 1/12/21 R7 had bilateral grab bars placed on bed. On 1/12/21 R4 had anti-slip materiel replaced under her fal	n.	

Facility ID: 00382

If continuation sheet Page 9 of 14

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	0938-039 E SURVEY	
			A. BUILDING	3		C	
		245399	B. WING		01/	01/12/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
LITTLE F	ALLS CARE CENTE	R		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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 689	severe cognitive im extensive with trans R7's Care plan revi for falls or injury reli interventions of nor and toilet, foot peda wheelchair mobility During observation floor in bedroom ar stickers on the floo R7's bed was push one bed rail on bed wall. During interview or assistant (NA)-A st have bed in low po NA-A stated she do anti skid strips on t During interview or stated R7 was to have incase she would the dementia and is a floo plan that indicates bed and bathroom missing. NA-C furth care plan that it sho rails on her bed an- that they intervention with reposition of re-	apairment. R7 requires sfers and bed mobility. ised 11/12/20, indicated at risk lated to cognitive deficits with n skid strips on floor by bed als to be used during provided by staff. on 1/11/21, at 1:10 p.m. R7's nd bathroom had no anti slip r by the bed or by the toilet. ed against the wall with only d on the side opposite of the 1/11/21, at 1:16 p.m. nursing ated R7 is a falls risk and is to sition with the mat on the floor. besn't believe that R7 has the he floor. 1/11/21, at 1:43 p.m. NA-B ave anti skid strips on the floor ry to stand up since she has falls risk. 1/11/21, at 2:32 p.m. NA-C risk and according to her care non skid grips to be on floor by and stated they appear to be her stated with looking at her ows she should have 2 bed d it only has one. NA-C stated ons are put in place to help esident and to prevent falls. these are missing they would	F 689	On 1/14/21, Facility implement room-move email checklist to plan interventions are put into residents move rooms. On 2/9/21 Nursing staff were r on the importance of following residents □ care plan/ NAR gro assignments. Director of Nursing and/or des complete random audits on ca interventions in relation to falls 1 week, 3x/week x 4weeks, an until QAPI committee determir longer needed. Director of Nur designee will correct issues ide through audits, including addin interventions and training staff Audits will be brought to the ne meeting to be evaluated for eff	ensure care place when e-educated the pup sheet ignee will re plan 5x/week x d weekly hes no sing and/or entified g as needed. ext QAPI		

If continuation sheet Page 10 of 14

		AND HUMAN SERVICES				FORM	: 04/01/2021 APPROVED . 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245399	B. WING			C 01/12/2021			
NAME OF F	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
	ALLS CARE CENTER	र	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 689	Continued From pa	ige 10	F	689					
	laying in bed with o	on 1/12/21, at 6:55 a.m. R7 nce side rail on bed, no anti floor next to bed or in							
	registered nurse (R intervention is on th that it is in place. So place to prevent R7 staff were aware th place she would ex	view on 1/12/21, at 9:24 a.m. RN)-A stated that if an the care plan she would expect tated interventions are put in 7 from falling. R7 stated that if at interventions were not in the pect them to notify nurse intervention could be put back							
	Director of Nursing risk. DON looked a stated that she sho and anti grip strips bathroom. DON sta still current as she a while and would r	1/12/21, at 10:10 a.m. (DON) stated R7 is a falls t care plan and on care plan uld have two bed rails on bed on the floor by bed and in ated she is not sure if these are has not gotten up by herself in need to speak with the case ther stated these interventions safety.							
	R4's facesheet date of Alzheimer's disea	ed 1/7/21, identified diagnosis ase.							
	11/24/20, indicated	nimum data set (MDS) dated R4 requires extensive assist mobility, transfers, toileting ne.							
	falls or injury related and wrist fracture.	ed 1/7/21, indicated at risk for d to recent diagnosis of left hip Further, care plan indicated sted of anti-slip material under							

		AND HUMAN SERVICES				FORM	04/01/2021 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED		
		245399	B. WING			C 01/12/2021			
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
	ALLS CARE CENTER	2	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 689	Continued From pa fall mat.	ge 11	F€	689					
		d 11/18/20, indicated R4 was per torso on the bed, and two s.							
	printed on 1/7/21, ir interventions includ bed rails, roam gua assess footwear, ar not in use. Further, frequently check R4 on floor out of bed,	led: low bed, fall mats, bilateral and left ankle, anti-roll backs, and fall mats out of reach when document indicated staff to 4, care-planned to place self and offer naps more -slip material under fall mats							
	was laying in bed, v	on 1/11/21, at 1:56 p.m. R4 with bed at lowest position with floor, however there were no nder the floor mat.							
	considered to be a Lindberg Park-Grou about the bolded le under mat, NA-D st	p.m. NA-D stated R4 was fall risk. NA-D referenced up A document. When asked tters for anti-slip material tated it is bolded because it is portant or it is new."							
	continued to lay in t and lifted up R4's fl should be under the goes on each side. rounds but that slip that. We did not loo	roximately 2:22 p.m. R4 bed. NA-D entered R4's room oor mat and stated "they e mat and there is one that We should have checked on ped my mind I won't lie about ok." Further, NA-D stated she the anti-slip material and							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COMP	PLETED
245399 B. WING	
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) 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. F 689 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 Summary and the stated falls F 689	
LITTLE FALLS CARE CENTER (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) 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. F 689 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 F 689	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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. F 689 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 F 689	
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	(X5) COMPLETION DATE
 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 	
consider a fall risk and majority of R4's falls have been out of bed. RN-B indicated falls	
Interventions are placed on the Lindherd Wark	
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. Eurther LPN B	
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.	

Facility ID: 00382

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		AND HUMAN SERVICES				FORM	04/01/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245399	B. WING				C 12/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ALLS CARE CENTER	7			1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Policy Fall prevented 10/12/17, indicated resident for their fall and with any signifi- will identify intervent and/or prevent injurs staff will conduct a interventions to pre- injury from further fall a resident's fall risk comprehensive fall to identify resident's visual impairment, l status and diagnost can contribute to fall analyzed. A summa	on and Management dated "The facility will assess each Il risk on admission, quarterly cant change in condition and ations to help prevent falls, ries from falls. if a fall occurs, root cause analysis to identify vent subsequent falls and/or alls" "Fall Risk assessment: If score is >/= to 9, a assessment will be completed s history of falls, activity level, balance and gait, elimination es and medications, etc. that Ils. The data gathered will be ary will be completed and e developed and implemented	F	589			

Facility ID: 00382

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Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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,

Dovertes Stapson

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

Little Falls Care Center February 2, 2021 Page 3 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

Minnesc	ta Department of He	alth				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		00382	B. WING			
NAME OF I	AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C 00382 B. WING O1/12/2021 DF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE E FALLS CARE CENTER 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345					
		1200 FIRS	ST AVENUE	NORTHEAST		
	ALLS CARE CENTER	LITTLE F	ALLS, MN 5	6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du	compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item				
	that may result fron orders provided tha the Department wit	n non-compliance with these it a written request is made to hin 15 days of receipt of a				
	On 1/6/21-1/12/21, conducted to detern Licensure. Your fac	an abbreviated survey was nine compliance with State ility was found to be NOT in				
	The following comp	laint was found to be				
Minnesota D	epartment of Health			<u> </u>		()(0) D : 75
	Y DIRECTOR'S OR PROVID ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	INAIURE	TITLE		(X6) DATE 02/12/21

6899

If continuation sheet 1 of 7

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		с	
		00382	B. WING			12/2021
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ITTLE F	ALLS CARE CENTE	R	ST AVENUE N ALLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	H5399044C-MN67 H5399043C-MN68 H5399045C-MN63					
	UNSUBSTANTIAT H5399046C-MN60 H5399040C-MN64 H5399041C-MN62 H5399042C MN64 The facility is enrol signature is not rec page of state form. Please indicate in y correction that you	152 840 488 803 and MN64842 led in ePOC and therefore a juired at the bottom of the first				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			4/12/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be our possible unless there is a the attending physician that the ain in bed or the resident n bed.	d t			
	by: Based on observat	ent is not met as evidenced ion, interview, and document ailed to implement care plan		Corrected		

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		COM	E SURVEY PLETED
		00382			C 12/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LITTLE F	FALLS CARE CENTE	R	ST AVENUE N ALLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 2	2 830			
	interventions to pre falls for 2 of 3 (R4	event the likelihood of potential and R7) residents.				
	Findings include:					
	R7's facesheet undated, identified diagnosis of Alzheimer disease, delusional disorders, hallucinations, major depressive disorders, previous hip fracture.					
	severe cognitive im	a set dated 9/17/20, identified npairment. R7 requires sfers and bed mobility.				
	for falls or injury re interventions of no	ised 11/12/20, indicated at risk lated to cognitive deficits with n skid strips on floor by bed als to be used during provided by staff.				
	floor in bedroom ar stickers on the floo R7's bed was push	on 1/11/21, at 1:10 p.m. R7's nd bathroom had no anti slip or by the bed or by the toilet. ned against the wall with only d on the side opposite of the				
	assistant (NA)-A st have bed in low po	n 1/11/21, at 1:16 p.m. nursing ated R7 is a falls risk and is to sition with the mat on the floor. besn't believe that R7 has the he floor.				
	stated R7 was to h	n 1/11/21, at 1:43 p.m. NA-B ave anti skid strips on the floor ry to stand up since she has falls risk.				
		n 1/11/21, at 2:32 p.m. NA-C risk and according to her care				

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:						
		00382	B. WING			C 12/2021			
AME OF	PROVIDER OR SUPPLIER								
ITTLE F	ALLS CARE CENTE	R	ST AVENUE N						
		ATEMENT OF DEFICIENCIES	ALLS, MN 56	PROVIDER'S PLAN OF	CORRECTION	()(5)			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
2 830	Continued From pa	age 3	2 830						
	bed and bathroom missing. NA-C furth care plan that it sho rails on her bed and that they intervention with reposition of re NA-C stated that if notify the nurse, ch they could put these During observation laying in bed with o	non skid grips to be on floor by and stated they appear to be her stated with looking at her ows she should have 2 bed d it only has one. NA-C stated ons are put in place to help esident and to prevent falls. these are missing they would arge nurse or maintenance so e back in place. on 1/12/21, at 6:55 a.m. R7 ince side rail on bed, no anti floor next to bed or in							
	registered nurse (R intervention is on th that it is in place. S place to prevent R7 staff were aware th place she would ex	view on 1/12/21, at 9:24 a.m. RN)-A stated that if an he care plan she would expect tated interventions are put in 7 from falling. R7 stated that if hat interventions were not in spect them to notify nurse intervention could be put back							
	Director of Nursing risk. DON looked a stated that she sho and anti grip strips bathroom. DON sta still current as she a while and would r	1/12/21, at 10:10 a.m. (DON) stated R7 is a falls t care plan and on care plan ould have two bed rails on bed on the floor by bed and in ated she is not sure if these are has not gotten up by herself in need to speak with the case ther stated these interventions safety.							
	R4's facesheet date of Alzheimer's dise	ed 1/7/21, identified diagnosis ase.							

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY		
			A. BUILDING:		C 01/12/20			
		00382	B. WING					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST								
LITTLE F	ALLS CARE CENTE	R	ST AVENUE N FALLS, MN 56					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
2 830	Continued From pa	age 4	2 830					
	11/24/20, indicated	nimum data set (MDS) dated I R4 requires extensive assist mobility, transfers, toileting ene.						
	falls or injury relate and wrist fracture.	ed 1/7/21, indicated at risk for ed to recent diagnosis of left hip Further, care plan indicated sted of anti-slip material under						
		ed 11/18/20, indicated R4 was oper torso on the bed, and two s.						
	printed on 1/7/21, i interventions includ bed rails, roam gua assess footwear, a not in use. Further, frequently check R on floor out of bed,	itled Lindbergh Park-Group A ndicated R4 safety ded: low bed, fall mats, bilatera ard left ankle, anti-roll backs, and fall mats out of reach when document indicated staff to 4, care-planned to place self and offer naps more i-slip material under fall mats						
	was laying in bed,	on 1/11/21, at 1:56 p.m. R4 with bed at lowest position with floor, however there were no nder the floor mat.						
	considered to be a Lindberg Park-Gro about the bolded le under mat, NA-D s	2 p.m. NA-D stated R4 was fall risk. NA-D referenced up A document. When asked etters for anti-slip material tated it is bolded because it is portant or it is new."						
		roximately 2:22 p.m. R4 bed. NA-D entered R4's room						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
ND FLAIN	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		-	
		00382	B. WING			C 12/2021
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	ALLS CARE CENTE	R				
		LITTLE F	ALLS, MN 56	345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 5	2 830			
	should be under the goes on each side. rounds but that slip that. We did not loo	loor mat and stated "they e mat and there is one that We should have checked on ped my mind I won't lie about ok." Further, NA-D stated she the anti-slip material and				
	2:32 through 3:03 p	observation on 1/11/21, from o.m. R4 continued to lay in bed terial was placed under floor				
	consider a fall risk been out of bed. Rl interventions are pl document to guide is a newer task or i it." RN-B confirmed mat was bolded rel sit on edge of bed a	laced on the Lindberg Park the nursing assistants and "if i f I want it to stick out I will bold anti-slip material under fall lated to R4 had been known to and kick the mat away from	t			
	expected to place t when R4 is in bed f mat from slipping if kick the mat.	N-B indicated staff were the material under the fall mat for safety and to prevent the f R4 were to slide out of bed or 3 a.m. LPN-B identified R4 as a				
	fall risk. LPN-B refe document for interv indicated anti-slip n being a new interve stated it was impor	erenced Lindberg Park ventions related to fall risk and naterial was bolded related to i ention for R4. Further, LPN-B tant for staff to place the				
	stay in place if she	mat to "to give more grip to tries to crawl out of bed and re of a fall risk and if that mat pt to fall."				
		l5 a.m. DON identified R4 as a				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			- (X3) DATE SURV COMPLETE				
	00382 B. WING		C 01/12/2021						
NAME OF I	PROVIDER OR SUPPLIER	STREET A	STREET ADDRESS, CITY, STATE, ZIP CODE						
ITTLE F	FALLS CARE CENTER		ST AVENUE N ALLS, MN 56						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
2 830	under the mat was or put herself on the and the fall to be as DON indicated staf the anti-slip materia place it under the n Policy Fall preventi 10/12/17, indicated resident for their fa and with any signifi will identify interver and/or prevent injurs staff will conduct a interventions to pre injury from further f a resident's fall risk comprehensive fall to identify resident's visual impairment, status and diagnos can contribute to fa analyzed. A summa interventions will be to mitigate the resident	an intervention if R4 does fall e floor "we want to protect her is safe as possible." Further, f were expected to check for al and if it was not there to nat. on and Management dated "The facility will assess each Il risk on admission, quarterly cant change in condition and titions to help prevent falls, ries from falls. if a fall occurs, root cause analysis to identify event subsequent falls and/or falls" "Fall Risk assessment: If s score is >/= to 9, a assessment will be completed s history of falls, activity level, balance and gait, elimination es and medications, etc. that ills. The data gathered will be ary will be completed and e developed and implemented							
	to assure residents necessaryservices from occuring. The designee, could co delivery of care; to services are impler implementation of t	to prevent or improve areas e director of nursing or nduct random audits of the ensure appropriate care and nented; to better ensure							