

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 Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met.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: 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

JOHNES LARROW

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: 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

PRINTED: 03/02/2021 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI			(X3) DATE SURVEY COMPLETED	
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	was completed at y complaint investiga NOT to be in completed.	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.					
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	The following comp UNSUBSTANTIATI H5399046C-MN60 H5399040C-MN648 H5399041C-MN624 H5399042C MN648	152 840 488					
		f correction (POC) will serve of compliance upon the optance.					
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ABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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

(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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	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 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				

NAME OF PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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: 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 17/21, 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. R6'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." 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 or abuse and guidelines for timely reporting. Licensed nurses were re-educated on the importance of notifying the Administrator immediately. 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 x.1 week, then 3x/week x.4 weeks, then onothly until QAPI committee determines no longer needed. Administrator will monitor corrective actions of maltreatment of a vulnerable adult that were reported to the State Age			R		1200 FIRST AVENUE NORTHEAST			
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: Findings include: Findings include: Findings include anxiety disorder and hip fracture. Staff also 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." 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 reprecue. Administrator and/or designee will implement corrective action for resident R4 affected by this practice. Administrator and/or designee will implement corrective action for resident R4 affected by this practice. Administrator and/or designee will implement corrective action for resident R4 affected by this practice. Administrator and/or designee will implement corrective actions for maltreatment or abuse and guidelines for timely member re-educated on the importance of notifying the Administrator immediately. The Administrator i	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
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 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.	F 609	Based on interview facility failed to report resident 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 proble cognitive skills for a R4's care plan date was vulnerable relaphysical condition. R5's quarterly MDS had diagnoses that disorder, and depressive the resident was physical condition. R5's progress note "Resident was physical condition." R5's progress note "R5's progress note "R6's progress note "R	w and document review, the ort an allegation of resident to the State Agency within two idents (R4, R5) reviewed for abuse allegations. Inimal data set (MDS) dated R4 had diagnoses that sorder and hip fracture. Staff R4 does have short and long ems with moderately impaired daily decision making. Initiated to cognitive status and a dated 10/28/20, indicated R5 included dementia, anxiety ession. Indicated 10/28/20, indicated R5 included dementia, anxiety ession. Indicated 12/11/20, indicated sically abused by another (R4) ing her room. A visitor (family in the next room witnessed the ed." In report dated 1/7/21, ed R4's room insisting that it is and R4 were talking loudly. Doset with R4 and FM-A R4 on R4's shin. FM-A was not it staff was present and took om. In p.m. family member (FM)- A	F	309	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 resic R4 affected by this practice. Administrator and/or designee will implement measures to ensure that practice does not reoccur. All facility will be re-educated on the proper procedure for Maltreatment Reporting including the types of maltreatment abuse and guidelines for timely report including the types of maltreatment abuse and guidelines for timely report including the types of maltreatment abuse and guidelines for timely report including the types of maltreatment abuse and guidelines for timely report including the types of the Administrator and designee will monitor corrective actions will monitor corrective actions by completing rangulation of maltreatmer vulnerable adult that were reported to state Agency to ensure they were reported timely. Audits will be completed adult x 1 week, 3x/week x 4weeks, then monthly until QAPI committee determines no longer new Audit results will be brought to the Committee quarterly for review and for the committee qu	this / staff ng or orting. on the trator /or ons to ctions ew , then til ger ndom nt of a to the leted chen eded. QAPI	

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F 609	and she reported the RN-A on 12/11/20. On 1/6/21, at 2:17 (LSW) indicated shincident on the more reviewed progress incident and began the incident should after it happened". is a mandated reported adult (VA) reference contact the director administrator with contact the director administrator with contact the director administrator with contact the incide by family member (R4. Further, RN stawas not that R5 kick verbal contradiction dated 12/11/20, writk verbiage of physical were going to emai past business hour "most definitely should be used." RN-A indic RN-A on reporting in the VA book to for report physical, finant neglect within "48 his sure." On 1/7/21, at 10:12 occurred on 12/11/20.	o.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 rter, and there is a vulnerable e book but staff are able to of nursing (DON) or	F6	609			

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F 609	the initial report to this incident should evening" and this in be reported within and the incident occurrence of the incident occurrence	staff have access for making the SA. Further, DON stated I have been reported "that neident would have needed to 24 hours due to no injury. Sa.m. Administrator indicated ed on 12/11/20, around 4:00 e aware of incident on Administrator indicated et trained on initial reporting. d staff were expected to report colicy and use our VA book to comething should be reported to ate." However, when asked not should have been reported, d "abuse is to be reported e is a willful infliction of injury ical harm pain or mental isse there was no harm to the eve it [the incident] would fall f abuse." Sa.m. registered nurse (RN)-B and aware of the incident on notified DON. Further, RN-B and report "anything that physical or verbal and things d report immediately. This we been reported upon the dent." Sa.m. DON confirmed abuse "immediately if there is an s, if there is no injury 24 hours. d have been reported within 24	F 60	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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dated 2/19/18, define possible, but not later allegation is made, allegation involve a injury, or not later the cause the allegation	nes immediately as "soon as ter than 2 hours after the if the events that cause the buse or result in serious bodily nan 24 hours if the events that n do not involve abuse and do					
Maltreatment Prohi indicated "staff will mechanism for this informed that they a reporters' if they sh mistreating a VA in definition is consider Free of Accident His	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 68	9		4/12/21	
The facility must er §483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and as	resident environment remains hazards as is possible; and resident receives adequate					
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa (LPN)-A indicated given at the beginn there was an altero however was not no reported. Further, L whoever sees it or the nurse that is the immediately if any s Facility policy Maltre dated 2/19/18, defin possible, but not late allegation is made, allegation is made, allegation involve a injury, or not later th cause the allegation not result in serious Facility policy Train Maltreatment Prohi 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 CFR(s): 483.25(d)(§483.25(d) Accider The facility must er §483.25(d)(1) The as free of accident §483.25(d)(2)Each	PROVIDER OR SUPPLIER FALLS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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." 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	PROVIDER OR SUPPLIER FALLS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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[` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	СОМ	(X3) DATE SURVEY COMPLETED	
		245399	B. WING			C 1 2/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	This REQUIREME by: Based on observareview the facility interventions to profalls for 2 of 3 (R4) Findings include: R7's facesheet un Alzheimer disease hallucinations, may previous hip fracture. R7's minimum data severe cognitive in extensive with transverse with transverse with transverse conductive interventions of noting and toilet, foot peowheelchair mobility. During observation floor in bedroom a stickers on the floor R7's bed was push one bed rail on be wall. During interview of assistant (NA)-A shave bed in low pon NA-A stated she danti skid strips on During interview of During interview of antity skid strips on During interview of the skid strips on During interview of the skid strips on During interview of the skid strips on the skid strips on During interview of the skid strips on the skid strips of the skid strips on the skid strips on the skid strips of the skid skid strips on the skid skid strips on the skid skid strips on the skid skid skid skid skid ski	eNT is not met as evidenced ation, interview, and document failed to implement care plan event the likelihood of potential and R7) residents. dated, identified diagnosis of experimental disorders, jor depressive disorders, jor depressive disorders, as set dated 9/17/20, identified impairment. R7 requires asfers and bed mobility. Avised 11/12/20, indicated at risk elated to cognitive deficits with on skid strips on floor by bed lals to be used during and provided by staff. In on 1/11/21, at 1:10 p.m. R7's and bathroom had no anti slip or by the bed or by the toilet. The diagrams the wall with only distributed against the wall with only distributed R7 is a falls risk and is to osition with the mat on the floor. The oesn't believe that R7 has the	F 6	It is LFHS policy to ensure that are free from Hazards/Supervision/Device residents □ environment remof accidents hazards as postall Prevention and Manage was reviewed by DON. On 1/12/21 R7 had Grip Strithe floor by her bed and in hon 1/12/21 R7 had bilateral placed on bed. On 1/12/21 Fanti-slip materiel replaced unmat. On 1/14/21, Facility impleme room-move email checklist to plan interventions are put intresidents move rooms. On 2/9/21 Nursing staff were on the importance of following residents □ care plan/ NAR gassignments. Director of Nursing and/or docomplete random audits on interventions in relation to fa 1 week, 3x/week x 4weeks, until QAPI committee determinger needed. Director of Nodesignee will correct issues through audits, including addinterventions and training standits will be brought to the meeting to be evaluated for	es and nains as free sible. Facility ement policy ips placed on her bathroom. grab bars R4 had hader her fall ented a to ensure care to place when e re-educated hig the group sheet esignee will care plan halls 5x/week x and weekly mines no lursing and/or identified ding aff as needed. hext QAPI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245399	B. WING		01	C / 12/2021	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		112/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 689	incase she would to dementia and is a second process. During interview or stated R7 is a falls plan that indicates bed and bathroom missing. NA-C furticare plan that it should be a stated that if notify the nurse, character of they could put these described by the place of the place of the place of the place of the place. Splace to prevent R staff were aware the place she would eximmediately so the in place. During interview or Director of Nursing risk. DON looked a stated that she should anti grip strips bathroom. DON states.	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 large nurse or maintenance so	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245399	B. WING			01/12/2021	
	PROVIDER OR SUPPLIER FALLS CARE CENTER	₹		12	REET ADDRESS, CITY, STATE, ZIP CODE 00 FIRST AVENUE NORTHEAST TTLE FALLS, MN 56345	, , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	manager. DON furtare put in place for R4's facesheet date of Alzheimer's disea R4's admission mir 11/24/20, indicated of two staff for bed and personal hygie R4's care plan date falls or injury relate and wrist fracture. I 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, at 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, w floor mat placed on anti-slip material ur 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 ruther, care plan indicated sted of anti-slip material under d 11/18/20, indicated R4 was per torso on the bed, and two second to be determined by the diagnosis of left hip ruther, care plan indicated R4 was per torso on the bed, and two second by the diagnosis of left hip ruther, care plan indicated R4 was per torso on the bed, and two second by the diagnosis of left hip ruther, care plan feet leads to be determined by the diagnosis of left hip ruther, care plan feet leads to be determined by the diagnosis of left hip ruther, care plan feet leads to be determined by the diagnosis of left hip ruther, and the diagnosis of left hip ruther, care plan feet leads to be diagnosis of left hip ruther, care plan indicated staff to diagnosis of left hip ruther, care plan indicated staff to diagnosis of left hip ruther, care plan indicated R4 was per torso on the bed, and two second left and left and the diagnosis of left hip ruther, care plan indicated R4 was per torso on the bed, and two second left and the diagnosis of left hip ruther, care plan indicated R4 was per torso on the bed, and two second left hip ruther, care plan indicated R4 was per torso on the bed, and two second left hip ruther, care plan indicated R4 was per torso on the bed, and two second left hip ruther, care plan indicated R4 was per torso on the bed, and two second left hip ruther, care plan indicated R4 was per torso on the bed, and two second left hip ruther, care plan indicated R4 was per torso on the bed, and truther left hip ruther, care plan indicated R4 was per torso on the bed, and two second left hip ruther, care plan indicated R4 was per torso on the bed, and two second left hip ruther left hip	F6	889			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED C		
		245399	B. WING		01	/12/2021	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COE 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		HOULD BE	(X5) COMPLETION DATE	
F 689	Lindberg Park-Grod about the bolded le under mat, NA-D sieither the "most im On 1/11/21, at appropriate on the propriate of the poes on each side. Tounds but that slip that. We did not look was unable to find exited R4's room. During continuous 2:32 through 3:03 pand no anti-slip materials. On 1/12/21, at 9:16 consider a fall risk been out of bed. RI interventions are plead ocument to guide is a newer task or it." RN-B confirmed mat was bolded relisit on edge of bed at the bed. Further, Rexpected to place to when R4 is in bed if mat from slipping if kick the mat. On 1/12/21, at 9:33 fall risk. LPN-B reference.	up A document. When asked atters 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 foor 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 is a.m. RN-B stated R4 was and majority of R4's falls have	F 6	89			
		naterial was bolded related to it ention for R4. Further, LPN-B					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245399	B. WING			I	C 12/2021
	PROVIDER OR SUPPLIER			S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	1 017	12/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	stated it was import material under the istay in place if she that makes her more open slips she is more open on 1/12/21, at 10:1 fall risk and to prevunder the mat was or put herself on the and the fall to be as DON indicated staff the anti-slip materia place it under the more place place it under the more place it	ant 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 of to fall." 5 a.m. DON identified R4 as a sent further injury anti-slip an intervention if R4 does fall re floor "we want to protect her as as possible." Further, if were expected to check for all and if it was not there to nat. In and Management dated "The facility will assess each I risk on admission, quarterly cant change in condition and tions to help prevent falls, it is from falls. If a fall occurs, root cause analysis to identify went subsequent falls and/or alls" "Fall Risk assessment: If score is >/= to 9, a assessment will be completed and medications, etc. that alls. The data gathered will be any will be completed and developed and implemented	F 6	889			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245399	B. WING				C 01/12/2021	
	PROVIDER OR SUPPLIER	R		120	REET ADDRESS, CITY, STATE, ZIP CODE 0 FIRST AVENUE NORTHEAST TLE FALLS, MN 56345	1 017	12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	ΓS	FC	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							
	As a result of the in were also identified	vestigations other deficiencies at F609.						
	The following comp UNSUBSTANTIATE H5399046C-MN60 H5399040C-MN64 H5399041C-MN624 H5399042C MN648	152 840 488						
		f correction (POC) will serve of compliance upon the otance.						
	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 liance.						
_ABORATOR\	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE	

02/12/2021

Electronically Signed

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
			A. DOILD				c
		245399	B. WING			01/	12/2021
	PROVIDER OR SUPPLIER	₹		12	TREET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST TTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the an attained in accordance with		000			4/42/24
	Exploitation The resident has the neglect, misapproper and exploitation as includes but is not lead to corporal punishment any physical or cheat the resident's §483.12(a) The fact §483.12(a)(1) Not uphysical abuse, con involuntary seclusions.	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. ility must- use verbal, mental, sexual, or poral punishment, or	F	0000			4/12/21
	Based on interview facility failed to ensabuse for 1 (R4) of observed to kick R4 Findings include: R4's admission mir 11/24/20, indicated included anxiety disalso indicated that I term memory problem.	and document review, the ure residents were free from 3 residents, when R5 was t's shin. simal data set (MDS) dated R4 had diagnoses that corder and hip fracture. Staff R4 does have short and long em with moderately impaired laily decision making.			It is LFHS policy to keep residents from abuse, neglect, and exploitation Director of Nursing and/or designed implement corrective action for resi R4, affected by this practice. A photo R4 and R5 have been placed at eye on their respective door frames as a intervention to assist residents in determining which room belongs to Director of Nursing and/or designed monitor corrective actions to ensure effectiveness of these actions included Social Services will interview randometrical properties.	on. e will dent to of e level an them. e will e the ding:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245399	B. WING			01/12/2021	
	PROVIDER OR SUPPLIEF			12	REET ADDRESS, CITY, STATE, ZIP CODE 200 FIRST AVENUE NORTHEAST TTLE FALLS, MN 56345	1 2 22	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	R4's care plan data was vulnerable rephysical condition R5's quarterly MD had diagnoses that disorder, and dep R5's progress not "Resident was phyaccusing her of ta member (FM)-A) incident and report and investigation perpetrator, who was R5's room. R R5 then became to member (FM)-A was R5's room. R R5 then became to member (FM)-A was not consider the solution of the reported to the solution of the reported to the solution of the more viewing progres incident and began on 1/6/21, at 2:29 indicated FM-A repassing" on 12/11	ted 1/7/21, indicated resident lated to cognitive status and . S dated 10/28/20, indicated R5 at included dementia, anxiety	F6	600	residents 5x/week x1 week, then x 4weeks, then monthly for three to ensure no complaints of maltre Director of Nursing or designee w complete audits of interventions the implemented to prevent further per abuse daily 5x/week, then 3x/week weeks, then monthly until QAPI committee determines no longer and Audit results will be brought to the committee quarterly for review an recommendation.	months atment. iill hat were otential ek x 4 heeded.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
		245399	B. WING_			C 12/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	1 017	12/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	seperated and extra the safety of both re On 1/7/21, at 10:12 stated immediate e RN-A regarding rep each resident name each room at eye le and extra monitorin Facility policy Maltre reviewed 2/19/18, in Services of Morris (safeguards to prohi neglect, and financi vulnerable adult in s review of facility polic "occurs when an ine addition, facility polic "occurs when an ine addition, facility polic (VA) to VA abuse as inflict injury upon ar the individual's actic inadvertent or accid the individual intend Even though a VA re	a monitoring added to ensure	F 60	00		
	Reporting of Alleger CFR(s): 483.12(c)(1) §483.12(c) In response neglect, exploitation must: §483.12(c)(1) Ensur		F 60	09		3/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245399	B. WING	···		C	
NAME OF F	PROVIDER OR SUPPLIER	2-1000		STREET ADDRESS, CITY, STATE, ZIP CODE	01/	12/2021	
	FALLS CARE CENTER	R		1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRESPONDED TO THE APPIDE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 609	source and misappare reported imme hours after the allet that cause the allet serious bodily injur the events that cauabuse and do not reported included anxiety dialso indicated that term memory prob	diding 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 use the allegation do not involve result in serious bodily injury, to fit the facility and to other to the State Survey Agency and rvices where state law provides ng-term care facilities) in tate law through established fort the results of all the 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 we and document review, the ort an allegation of resident to the State Agency within two sidents (R4, R5) reviewed for	F 6	It□s LFHS policy to report alleg violations of abuse, neglect, or mistreatment in a timely manne Administrator and/or designee vimplement corrective action for R4 affected by this practice. Administrator and/or designee vimplement measures to ensure practice does not reoccur. All fa will be re-educated on the proper procedure for Maltreatment Rejincluding the types of maltreatment abuse and guidelines for timely Licensed nurses were re-educated.	r. vill resident vill that this cility staff er porting nent or reporting.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	` ´COM	E SURVEY PLETED
		245399	B. WING			C 12/2021
	PROVIDER OR SUPPLIER FALLS CARE CENTER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 609	R4's care plan date was vulnerable relaphysical condition. R5's quarterly MDS had diagnoses that disorder, and depression of the "Resident was physical cusing her of tak member (FM)-A) in incident and reported Internal investigation indicated R5 enterewas R5's room. R5 R5 then became upwitnessed R5 kick able to intervene ur R5 back to R5's room. On 1/6/21, at 12:50 indicated on 12/11/2 and she reported the RN-A on 12/11/20. On 1/6/21, at 2:17 p(LSW) indicated shincident on the more reviewed progress incident and began the incident should after it happened". is a mandated reported to the recommendation of the more reviewed progress incident and began the incident should after it happened". is a mandated reported to the recommendation of the more reviewed progress incident and began the incident should after it happened". is a mandated reported to the recommendation of the more reviewed progress incident and began the incident should after it happened". is a mandated reported to the recommendation of the recommendation	d 1/7/21, indicated resident ited to cognitive status and dated 10/28/20, indicated R5 included dementia, anxiety ession. dated 12/11/20, indicated sically abused by another (R4) ing her room. A visitor (family the next room witnessed the ed." on report dated 1/7/21, ed R4's room insisting that it and R4 were talking loudly. Set with R4 and FM-A R4 on R4's shin. FM-A was ntil staff was present and took om. p.m. family member (FM)- A 20, she witnessed R5 kick R4 incident immediately to one. LSW reported the the investigation. LSW stated have been reported "right Further, LSW stated everyone of the room of nursing (DON) or	F 609	immediately. The Administrator a designee will monitor corrective ensure the effectiveness of thes including Social Services will interandom residents 5x/week x1 was/week x 4weeks, then monthly QAPI committee determines no needed. Administrator will monit corrective actions by completing audits on allegations of maltreat vulnerable adult that were report State Agency to ensure they were reported timely. Audits will be condaily x 1 week, 3x/week x 4week monthly x then monthly until QA committee determines no longer Audit results will be brought to the committee quarterly for review a recommendation.	actions to e actions erview eek, then / until longer or random ment of a ted to the re empleted ks, then PI r needed. ne QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245399	B. WING_		01	/12/2021	
	PROVIDER OR SUPPLIER FALLS CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CO 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 609	confirmed he wrote record dated 12/11 notified of the incide by family member R4. Further, RN st was not that R5 kie verbal contradictio dated 12/11/20, wriverbiage of physica were going to emapast business hour "most definitely shout I don't know the abuse." RN-A indic RN-A on reporting in the VA book to for report physical, finineglect within "48 sure." On 1/7/21, at 10:12 occurred on 12/11/ aware of incident call licensed nursing the initial report to this incident should evening" and this incident occurred. The incident occurred in the incident occurrent on 1/7/21, at 10:50 the incident occurrent on 1/7/21, at 10:50 the incident occurrent of the incident occurrent occurrent of the incident occurrent occurren	age 6 p.m. registered nurse (RN)-A e the progress note in R5's /20. RN-A indicated he was lent "in passing" on 12/11/20, (FM)-A who witnessed R5 kick ated that the report he received cked R4, at that time it was a n. However, progress note tten by RN-A, does use the ally abused. RN-A stated they ill the DON due to it being well rs. However, RN-A stated ould have reported soon after, e time frame for reporting cated the facility had trained abuse and there is a template follow. RN-A stated they would ancial, sexual abuse, and hours or its 12 hours, I am not 2 a.m. DON stated the incident /20, but she was not made until 12/14/20. DON indicated g staff have access for making the SA. Further, DON stated d have been reported "that incident would have needed to 24 hours due to no injury. 3 a.m. Administrator indicated ded on 12/11/20, around 4:00 e aware of incident on Administrator indicated e trained on initial reporting. ed staff were expected to report policy and use our VA book to omething should be reported to tate." However, when asked	F 60	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C	
		245399	B. WING _		01	// 12/2021	
	PROVIDER OR SUPPLIER FALLS CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	•		
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F 609	about when incide Administrator state immediately. Abus with resulting phys anguish, but becauresident I don't belinto the category of On 1/7/21, at 11:16 stated they were made 12/14/20, and ther indicated they wou warrants a VA, like of that matter woul incident should has moment of the incident should be reported injury, it's two hours incident should be reported injury, it's two hours since there would be incident should be reported injury, it's two hours since there would be reported injury, it's two hours since there was an altered given at the begins there was an altered however was not reported. Further, whoever sees it or the nurse that is the immediately if any Facility policy Maltidated 2/19/18, defipossible, but not la allegation is made	nt should have been reported, and "abuse is to be reported e is a willful infliction of injury ical harm pain or mental use there was no harm to the ieve it [the incident] would fall f abuse." So a.m. registered nurse (RN)-B hade aware of the incident on a notified DON. Further, RN-B ld report "anything that e physical or verbal and things id report immediately. This we been reported upon the dent." So a.m. DON confirmed abuse I "immediately if there is an s, if there is no injury 24 hours. It had been reported within 24	F 60	9			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		SURVEY				
		245399	B. WING _		01/1	; 2/2021
	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
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	cause the allegation not result in serious Facility policy Train Maltreatment Prohi indicated "staff will mechanism for this informed that they a reporters' if they sh mistreating a VA in definition is consideree of Accident Hac CFR(s): 483.25(d) (Section 1988) 483.25(d) (1) The facility must en §483.25(d)(1) The	inan 24 hours if the events that in do not involve abuse and do is 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) ints. issure that -	F 68			3/12/21
	§483.25(d)(2)Each supervision and assaccidents. This REQUIREMED by: Based on observatoreview the facility fainterventions to prefalls for 2 of 3 (R4 at Findings include: R7's facesheet und Alzheimer disease, hallucinations, majorevious hip fracture.	ated, identified diagnosis of delusional disorders, or depressive disorders,		It is LFHS policy to ensure that Res are free from Hazards/Supervision/Devices and residents □ environment remains as of accidents hazards as possible. Far Fall Prevention and Management powas reviewed by DON. On 1/12/21 R7 had Grip Strips place the floor by her bed and in her bathron 1/12/21 R7 had bilateral grab bat placed on bed. On 1/12/21 R4 had anti-slip materiel replaced under her mat.	free acility blicy ed on coom.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245399	B. WING		l l	12/2021
	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
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F 689	severe cognitive imextensive with tran R7's Care plan rev for falls or injury reinterventions of not and toilet, foot ped wheelchair mobility During observation floor in bedroom ar stickers on the floor R7's bed was push one bed rail on bedwall. During interview or assistant (NA)-A st have bed in low pon NA-A stated she do anti skid strips on the case she would the dementia and is a find that indicates bed and bathroom missing. NA-C further care plan that it she rails on her bed and that they intervention with reposition of ren NA-C stated that if	repairment. R7 requires sfers and bed mobility. Issed 11/12/20, indicated at risk lated to cognitive deficits with a skid strips on floor by bed als to be used during provided by staff. In 1/11/21, at 1:10 p.m. R7's and bathroom had no anti slip r by the bed or by the toilet. ed against the wall with only if on the side opposite of the in 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. The she floor. In 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. In 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 the stated with looking at her pows she should have 2 bed dit 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	F 689	On 1/14/21, Facility implemented room-move email checklist to en plan interventions are put into platesidents move rooms. On 2/9/21 Nursing staff were recon the importance of following the residents care plan/ NAR group assignments. Director of Nursing and/or design complete random audits on care interventions in relation to falls 5.1 week, 3x/week x 4weeks, and until QAPI committee determines longer needed. Director of Nursing designee will correct issues iden through audits, including adding interventions and training staff as Audits will be brought to the next meeting to be evaluated for effective to the state of the s	sure care ace when educated e o sheet nee will plan k/week x weekly s no ng and/or tified s needed. QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245399	B. WING _		01	C / 12/2021	
	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From pa	ge 10 on 1/12/21, at 6:55 a.m. R7	F 68	9			
	laying in bed with o	nce side rail on bed, no anti floor next to bed or in					
	registered nurse (R intervention is on the that it is in place. So place to prevent R7 staff were aware the place she would ex	view on 1/12/21, at 9:24 a.m. (N)-A stated that if an the care plan she would expect tated interventions are put in 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 statill current as she a while and would residue.	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 her stated these interventions safety.					
	R4's facesheet date of Alzheimer's disease	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 relate and wrist fracture. I	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					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED C
		245399	B. WING		01	/12/2021
	PROVIDER OR SUPPLIER FALLS CARE CENTER	₹		STREET ADDRESS, CITY, STATE, ZIP COD 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 CORRECTIVE ACTION SHORES (CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 689	fall mat. Progress note date found on knees, up abrasions on knees Facility document t printed on 1/7/21, ii interventions included assess footwear, a not in use. Further, frequently check Roon floor out of bed, frequently, and antiwere typed in bold. During observation was laying in bed, of floor mat placed on anti-slip material ur On 1/11/21, at 2:22 considered to be a Lindberg Park-Grounds about the bolded leunder mat, NA-D seither the "most im on 1/11/21, at appropriate to lay in and lifted up R4's floor should be under the goes on each side, rounds but that slip that. We did not local side.	ed 11/18/20, indicated R4 was oper torso on the bed, and two sections. itled Lindbergh Park-Group Andicated R4 safety ded: 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 i-slip material under fall mats on 1/11/21, at 1:56 p.m. R4 with bed at lowest position with a floor, however there were no	F 6	89		

		IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245399	B. WING		01	C / 12/2021	
	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP C 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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) COMPLETION DATE	
F 689	During continuous of 2:32 through 3:03 pand no anti-slip mamat. On 1/12/21, at 9:16 consider a fall risk abeen out of bed. Rinterventions are pleadocument to guide is a newer task or it." RN-B confirmed mat was bolded relisit on edge of bed at the bed. Further, Rexpected to place the when R4 is in bed finat from slipping if kick the mat. On 1/12/21, at 9:33 fall risk. LPN-B refedocument for intervindicated anti-slip in being a new intervestated it was import material under the stay in place if she that makes her more of the control of the mat was or put herself on the and the fall to be as DON indicated staff.	a.m. RN-B stated R4 was and majority of R4's falls have N-B indicated falls acced on the Lindberg Park the nursing assistants and "if it I want it to stick out I will bold anti-slip material under fall ated to R4 had been known to and kick the mat away from N-B indicated staff were he material under the fall mat or safety and to prevent the R4 were to slide out of bed or a.m. LPN-B identified R4 as a strenced Lindberg Park entions related to fall risk and naterial was bolded related to it ention for R4. Further, LPN-B thant for staff to place the mat to "to give more grip to the staff to give more grip to the of a fall risk and if that mat of to fall." 5 a.m. DON identified R4 as a sent further injury anti-slip an intervention if R4 does fall the floor "we want to protect her as safe as possible." Further, if were expected to check for all and if it was not there to	F 6	89			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245399	B. WING		01	C / 12/2021
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	Policy Fall preventing 10/12/17, indicated resident for their far and with any significant will identify interver and/or prevent injustaff will conduct a interventions to presinjury from further that is a resident's fall risk comprehensive fall to identify resident' visual impairment, status and diagnos can contribute to far analyzed. A summare	on and Management dated I "The facility will assess each Ill risk on admission, quarterly ideant change in condition and intions 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 a score is >/= to 9, a l assessment will be completed as history of falls, activity level, balance and gait, elimination the sand medications, etc. that alls. The data gathered will be ary will be completed and the developed and implemented	F 6	89		



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,

Douglas Larson, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Jovens Stapson

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00382		B. WING		01/1	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LITTLE I	FALLS CARE CENTER	2	ST AVENUE ALLS, MN 5	NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section 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 fines promulgated by rule of artment of Health.				
	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	nether a violation has been compliance with all a rule provided at the tag ule number indicated below. In the several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will ament of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted to determ Licensure. Your fac	rs: an abbreviated survey was mine compliance with State dility was found to be NOT in MN State Licensure.				
	The following comp SUBSTANTIATED:	laint was found to be				

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

Electronically Signed 02/12/21

TITLE

STATE FORM 6899 ATZJ11 If continuation sheet 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
00382		B. WING		C 01/12/2021		
	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE NORTHEAST	, , , , ,	
	ALLO GARL GERTLI	LITTLE FA	ALLS, MN 5	6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	The following comp UNSUBSTANTIATI H5399046C-MN602 H5399040C-MN624 H5399042C MN648 The facility is enroll signature is not req page of state form. Please indicate in y correction that you and identify the date	086 136 100 with an order cited. claint was found to be ED: 152 340 488 303 and MN64842 ed in ePOC and therefore a uired at the bottom of the first our electronic plan of have reviewed these orders, e when they will be completed.	2 000			4/12/21
2 830	Proper Nursing Car Subpart 1. Care in receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must rema prefers to remain in This MN Requirement by: Based on observation	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the in in bed or the resident	2 830	Corrected		4/12/21

Minnesota Department of Health

STATE FORM 6899 ATZJ11 If continuation sheet 2 of 7

	(X3) DATE SURVEY COMPLETED	
00382 B. WING 01/12/	2/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
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		

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	1 ` ') DATE SURVEY COMPLETED	
7 WE TE WE TO GET WEET THE T		BENTI TOATION NOMBER.	A. BUILDING:	JILDING:			
	00382		B. WING		01/1	2/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LITTLE	FALLS CARE CENTER	₹		NORTHEAST			
		LITTLE FA	ALLS, MN 5	6345			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 3	2 830				
	plan that indicates in bed and bathroom is missing. NA-C furth care plan that it sho rails on her bed and that they intervention with reposition of reconstruction in the position of reconstruction in the position of reconstruction is constructed by the nurse, characteristic control is a position of the position in the place of the place is and bathroom. During phone intervention is on the place to prevent R7 staff were aware the place she would extend to the place in	non skid grips to be on floor by and stated they appear to be her stated with looking at her lows she should have 2 bed do 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					
	in place. During interview on 1/12/21, at 10:10 a.m.						
	Director of Nursing risk. DON looked at stated that she sho and anti grip strips bathroom. DON stated that still current as she a while and would result in the strip of the s	(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 sted she is not sure if these are has not gotten up by herself in need to speak with the case her stated these interventions					
	R4's facesheet date of Alzheimer's disea	ed 1/7/21, identified diagnosis ase.					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	00382		B. WING		C 01/12/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LITTLE F	LITTLE FALLS CARE CENTER 1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	R4's admission min 11/24/20, indicated of two staff for bed and personal hygier R4's care plan date falls or injury related and wrist fracture. Finterventions consist fall mat. Progress note date found on knees, up abrasions on knees Facility document tiprinted on 1/7/21, ir interventions includ bed rails, roam gua assess footwear, and in use. Further, frequently check R4 on floor out of bed, frequently, and antiwere typed in bold. During observation was laying in bed, w floor mat placed on anti-slip material undon 1/11/21, at 2:22 considered to be a Lindberg Park-Grouabout the bolded lei under mat, NA-D steither the "most imp	imum data set (MDS) dated R4 requires extensive assist mobility, transfers, toileting ne. d 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 is. tled Lindbergh Park-Group A ndicated R4 safety ed: low bed, fall mats, bilateral rd 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 der the floor mat. p.m. NA-D stated R4 was fall risk. NA-D referenced up A document. When asked tters for anti-slip material ated it is bolded because it is	2 830				
		ped_NA-D entered R4's room					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00382	B. WING			C 12/2021
	PROVIDER OR SUPPLIER	1200 FIRS		STATE, ZIP CODE NORTHEAST 6345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	and lifted up R4's fl should be under the goes on each side. rounds but that slip that. We did not look was unable to find the exited R4's room. During continuous 2:32 through 3:03 pand no anti-slip marmat. On 1/12/21, at 9:16 consider a fall risk abeen out of bed. R1 interventions are pleadocument to guide is a newer task or it." RN-B confirmed mat was bolded relisit on edge of bed at the bed. Further, R1 expected to place the when R4 is in bed from slipping if kick the mat. On 1/12/21, at 9:33 fall risk. LPN-B reference document for intervindicated anti-slip in being a new intervestated it was import material under the stay in place if she that makes her more of the control of the c	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 a.m. RN-B stated R4 was and majority of R4's falls have N-B indicated falls acced on the Lindberg Park the nursing assistants and "if it I want it to stick out I will bold anti-slip material under fall ated to R4 had been known to and kick the mat away from N-B indicated staff were he material under the fall mat or safety and to prevent the R4 were to slide out of bed or a.m. LPN-B identified R4 as a strenced Lindberg Park rentions related to fall risk and naterial was bolded related to it ention for R4. Further, LPN-B 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				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00382		B. WING			C 1 2/2021
	PROVIDER OR SUPPLIER	1200 FIRS		STATE, ZIP CODE NORTHEAST 6345	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	under the mat was or put herself on the and the fall to be as DON indicated staff the anti-slip materia place it under the mode of the anti-slip materia place it under the mode of the anti-slip materia place it under the mode of the anti-slip materia place it under the mode of the anti-slip materia place it under the mode of the anti-slip material place it under the mode of the anti-slip material place it under the mode of the anti-slip material place in the place of the anti-slip material place of the an	an intervention if R4 does fall a floor "we want to protect her is safe as possible." Further, if were expected to check for all and if it was not there to nat. On and Management dated "The facility will assess each I risk on admission, quarterly cant change in condition and tions 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 a history of falls, activity level, calance and gait, elimination and medications, etc. that a developed and implemented and a developed and implemented dent's fall risk." of Correction: The Directior of the could review policies and aff, and implement measures are receiving the to prevent or improve areas and including appropriate care and mented; to better ensure	2 830			

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