Electronically Delivered
October 1, 2021

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

RE: CCN: 245399
Cycle Start Date: October 1, 2021

Dear Administrator:

On September 21, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

August 30, 2021

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

RE: CCN: 245399
Cycle Start Date: August 20, 2021

Dear Administrator:

On August 20, 2021, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 November 20, 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 February 20, 2022 (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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	C 08/20/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/19/21 and 8/20/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5399051C (MN00075560), with a deficiency cited at F760. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an insulin (regulates the amount of glucose in the blood) order was correctly transcribed and administered in accordance with physician orders for 1 of 2 residents (R1) reviewed for medication errors.	F 760	R1□s insulin order was transcribed on 8/4 All residents that receive medications have the potential to have significant medications errors. Policies and procedures related to order	9/17/21

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

Electronically Signed | 09/09/2021

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

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F 760	Continued From page 1 Findings include: R1's admission Minimum Data Set (MDS), dated 8/4/21, identified R1 had a diagnosis of diabetes mellitus (DM) and received insulin. R1's admission orders signed 7/27/21, directed the following order: "insulin glargine 100 unit/mL pen. Commonly known as: LANTUS SOLOSTRAR. Inject 15 Units subcutaneous (SQ) as directed. See insulin instructions." The associated diagnosis identified DM type 2, uncontrolled, with renal complications. The insulin instructions directed to administer 20 units at breakfast. The orders were co-signed by two nursing home staff members; one signed by the health unit coordinator/licensed practical nurse (LPN)-A on 7/28/21 and the other by registered nurse (RN)-A on 8/4/21 (eight (8) days after admission). The order lacked evidence of a second nurse check having been performed on 7/28/21, per facility policy. R1's Order Clarification Request dated 7/28/21, identified LPN-A requested a clarification regarding the Lantus order. The request identified a medical provider telephone order response was obtained by RN-B on 7/28/21, which ordered Lantus 15 units SQ every morning. A second check of the Lantus clarification was performed by RN-A on 8/4/21. The request lacked documentation of a second nurse check having been performed on 7/28/21, per facility policy. R1's EMAR [electronic medication administration record] Report for July 2021, identified all medications R1 was administered during the month since admission.	F 760	processing and medication errors have been reviewed and revised. The DON has created a new medication error education form to utilize for errors and education. All nursing staff were educated on order transcription, the order entry process, and medication errors. All residents who are admitted will have their medication orders second checked by the DON or RN designee for proper transcription and entry within 24 hours of admission. Audits will be completed by DON or designee to ensure second check was completed within 24 hours. All admissions in the next 30 days will be audited. Then we will audit 3 admissions monthly for 2 months and then 1 month thereafter. Audit reports will be brought to QAPI committee for review and further recommendations.	

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F 760	Continued From page 2	F 760		

R1's EMAR Report for August 2021, identified the Lantus15 units once a day order, ordered on 7/27/21, was initially entered into the EMR on 8/4/21, and first administered on 8/5/21.

R1's Blood Sugar Recordings report dated 7/28/21 - 8/4/21, identified R1's blood sugars ranged from 130 mg/dL to 196 mg/dL.

R1's Blood Sugar Recordings report dated 8/5/21 - 8/14/21, identified R1's blood sugars ranged from 107 mg/dL to 364 mg/dL.

An Incident Details report dated 8/4/21, identified R1's Lantus medication error occurred on 7/29/21, when the "Order for use of Lantus was not entered into system [EMR] upon receiving clarification."

During interview on 8/20/21, at 11:16 a.m. case manager RN-C acknowledged R1's Lantus omission was a significant medication error. RN-C stated she was not involved with the medication error investigation and thus was not aware of what caused the error to occur or any identified follow-up. RN-C did not complete any medication order audits to ensure orders were correctly processed per facility protocols and further did not review other resident's insulin orders to ensure accuracy. All orders were reviewed by two nurses to ensure accuracy, in which the second nurse "usually" completed the "second check right away" after the first nurse entered the orders into the EMR. If the second check could not be completed right away the first nurse would flag the chart for other [floor] nurses to indicate the orders required attention. RN-C expected R1's Lantus order to be checked sooner

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F 760	Continued From page 3	F 760		

[than 8/4/21], in which she expressed the importance of the second nurse check was "to catch any errors." She stated if errors were not caught then the residents were "at risk for not getting the right dose or medication."

When interviewed on 8/20/21, at 11:35 a.m. LPN-A stated she primarily processed all initial orders and clarification requests. After LPN-A processed resident order(s) into the EMR she would often pull another office nurse to perform the second nurse order check. If she was unable to utilize an office nurse, she flagged the chart using the designated chart flagging system and placed a double/triple check processing slip into the designated area at the nurses station. This would alert the floor nurse that the initial check had been completed and that the second check was still required. LPN-A stated she flagged R1's chart on 7/28/21, to prompt the floor nurses R1's admission orders still required the double check process.

- LPN-A did not know why some of R1's clarification orders were processed on 7/29/21 and the Lantus was not. LPN-A was "minimally" involved with R1's Lantus medication error investigation and did not know if systemic interventions or follow up as a result of the error occurred to ensure this was an isolated event for R1 only. LPN-A explained she expected the double check to be done by the on duty floor nurse the day prior to R1 having been administered any admission ordered or clarified medications. LPN-A stated risk factors associated with orders not double checked in a timely manner could lead to overdose of medication, toxicity of blood levels, or other adverse effects from improper medication administration.

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F 760	Continued From page 4	F 760		

During interview on 8/20/21, at 11:56 a.m. RN-C stated admission orders were typically processed by [LPN-A] or the admission nurse prior to the residents admission. RN-C remembered R1's admission to the facility on 7/28/21; however, she felt R1's admission did not occur until around 12:00 p.m. to 1:00 p.m. RN-C typically checks "the bin" [designated spot for order processing slips awaiting double checks] around "10:30 a.m. or so" and then typically does not check the bin after, due to proceeding medication passes. "Whoever looks in the bin where the little sheets are placed by [LPN-A] would then check the orders"; however, RN-C additionally added, "I honestly cannot tell you, I do not know when orders should be checked."

- Further, RN-C did not double check R1's admission and/or clarification orders on 7/28/21, and would have double checked R1's orders that day if she would have had time. RN-C reviewed R1's admission and clarification orders and she stated, "That is a long time [8 days after admission] before a new person [resident] had their orders checked. Should have been [checked] before that". RN-C stated "Oh wow! That is not good." when RN-C was shown R1's Lantus order was not transcribed timely. RN-C denied receiving education or any other follow up related to R1's Lantus error.

When interviewed on 8/20/21, at 12:25 p.m. the director of nursing (DON) stated, "On a typical day [LPN-A] does [processes] all admission orders." If there was an RN that double checked the orders right away "then nothing else happens and it is good to go." If there is not an RN available right away to double check the orders,

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F 760	Continued From page 5	F 760		

then LPN-A completes the designated slip of paper indicating what order processes are left for the floor nurses to complete and brings it to the nurses station where she would expect the floor nurses to complete the second order check.

- The DON stated she expected admission orders to be double checked within 24 hours of a residents admission and if a nurse was required to administer a medication prior to the double check then that nurse should verify the order with the admission orders in the resident's chart. The DON only educated LPN-A and RN-B regarding R1's Lantus error related to the initial transcription error of the clarification order directives and commented, "[I] should have went back and followed up on why it was not double checked." The DON further denied she had completed any audits or further follow up to ensure other residents received their medications as prescribed. The DON stated R1's risk of not having received her Lantus as ordered could have resulted in hypoglycemic (low blood sugar) or hyperglycemic (high blood sugar) reactions in which, "It could have went any way for her [R1]."

A policy, Medication Errors, reviewed 7/2/14, indicated "Residents of LFHS [Little Falls Health Services] will receive medication in accordance with their physician's order and in compliance with State and Federal Regulations."

Electronically delivered
August 30, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: N35J11

Dear Administrator:

The above facility was surveyed on August 19, 2021 through August 20, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/19/21 and 8/20/21, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed the order and identify the date when it will be completed.	2 000		

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

Electronically Signed | 09/09/21

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5399051C (MN00075560), with a licensing order issued at MN Rule 4658.1320 A.B.C 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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	00382	A. BUILDING: _____ B. WING _____	C 08/20/2021

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2 000	Continued From page 2 state form. 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.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the	21545		9/17/21

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21545	Continued From page 3 physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an insulin (regulates the amount of glucose in the blood) order was correctly transcribed and administered in accordance with physician orders for 1 of 2 residents (R1) reviewed for medication errors. Findings include: R1's admission Minimum Data Set (MDS), dated 8/4/21, identified R1 had a diagnosis of diabetes mellitus (DM) and received insulin. R1's admission orders signed 7/27/21, directed the following order: "insulin glargine 100 unit/mL pen. Commonly known as: LANTUS SOLOSTRAR. Inject 15 Units subcutaneous (SQ) as directed. See insulin instructions." The associated diagnosis identified DM type 2, uncontrolled, with renal complications. The insulin instructions directed to administer 20 units at breakfast. The orders were co-signed by two	21545	Corrected	

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21545	Continued From page 4	21545		

nursing home staff members; one signed by the health unit coordinator/licensed practical nurse (LPN)-A on 7/28/21 and the other by registered nurse (RN)-A on 8/4/21 (eight (8) days after admission). The order lacked evidence of a second nurse check having been performed on 7/28/21, per facility policy.

R1's Order Clarification Request dated 7/28/21, identified LPN-A requested a clarification regarding the Lantus order. The request identified a medical provider telephone order response was obtained by RN-B on 7/28/21, which ordered Lantus 15 units SQ every morning. A second check of the Lantus clarification was performed by RN-A on 8/4/21. The request lacked documentation of a second nurse check having been performed on 7/28/21, per facility policy.

R1's EMAR [electronic medication administration record] Report for July 2021, identified all medications R1 was administered during the month since admission.

R1's EMAR Report for August 2021, identified the Lantus15 units once a day order, ordered on 7/27/21, was initially entered into the EMR on 8/4/21, and first administered on 8/5/21.

R1's Blood Sugar Recordings report dated 7/28/21 - 8/4/21, identified R1's blood sugars ranged from 130 mg/dL to 196 mg/dL.

R1's Blood Sugar Recordings report dated 8/5/21 - 8/14/21, identified R1's blood sugars ranged from 107 mg/dL to 364 mg/dL.

An Incident Details report dated 8/4/21, identified R1's Lantus medication error occurred on 7/29/21, when the "Order for use of Lantus was

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21545	Continued From page 5 not entered into system [EMR] upon receiving clarification." During interview on 8/20/21, at 11:16 a.m. case manager RN-C acknowledged R1's Lantus omission was a significant medication error. RN-C stated she was not involved with the medication error investigation and thus was not aware of what caused the error to occur or any identified follow-up. RN-C did not complete any medication order audits to ensure orders were correctly processed per facility protocols and further did not review other resident's insulin orders to ensure accuracy. All orders were reviewed by two nurses to ensure accuracy, in which the second nurse "usually" completed the "second check right away" after the first nurse entered the orders into the EMR. If the second check could not be completed right away the first nurse would flag the chart for other [floor] nurses to indicate the orders required attention. RN-C expected R1's Lantus order to be checked sooner [than 8/4/21], in which she expressed the importance of the second nurse check was "to catch any errors." She stated if errors were not caught then the residents were "at risk for not getting the right dose or medication." When interviewed on 8/20/21, at 11:35 a.m. LPN-A stated she primarily processed all initial orders and clarification requests. After LPN-A processed resident order(s) into the EMR she would often pull another office nurse to perform the second nurse order check. If she was unable to utilize an office nurse, she flagged the chart using the designated chart flagging system and placed a double/triple check processing slip into the designated area at the nurses station. This would alert the floor nurse that the initial check had been completed and that the second check	21545		

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21545	Continued From page 6	21545		

was still required. LPN-A stated she flagged R1's chart on 7/28/21, to prompt the floor nurses R1's admission orders still required the double check process.

- LPN-A did not know why some of R1's clarification orders were processed on 7/29/21 and the Lantus was not. LPN-A was "minimally" involved with R1's Lantus medication error investigation and did not know if systemic interventions or follow up as a result of the error occurred to ensure this was an isolated event for R1 only. LPN-A explained she expected the double check to be done by the on duty floor nurse the day prior to R1 having been administered any admission ordered or clarified medications. LPN-A stated risk factors associated with orders not double checked in a timely manner could lead to overdose of medication, toxicity of blood levels, or other adverse effects from improper medication administration.

During interview on 8/20/21, at 11:56 a.m. RN-C stated admission orders were typically processed by [LPN-A] or the admission nurse prior to the residents admission. RN-C remembered R1's admission to the facility on 7/28/21; however, she felt R1's admission did not occur until around 12:00 p.m. to 1:00 p.m. RN-C typically checks "the bin" [designated spot for order processing slips awaiting double checks] around "10:30 a.m. or so" and then typically does not check the bin after, due to proceeding medication passes. "Whoever looks in the bin where the little sheets are placed by [LPN-A] would then check the orders"; however, RN-C additionally added, "I honestly cannot tell you, I do not know when orders should be checked."

- Further, RN-C did not double check R1's

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21545	Continued From page 7 admission and/or clarification orders on 7/28/21, and would have double checked R1's orders that day if she would have had time. RN-C reviewed R1's admission and clarification orders and she stated, "That is a long time [8 days after admission] before a new person [resident] had their orders checked. Should have been [checked] before that". RN-C stated "Oh wow! That is not good." when RN-C was shown R1's Lantus order was not transcribed timely. RN-C denied receiving education or any other follow up related to R1's Lantus error. When interviewed on 8/20/21, at 12:25 p.m. the director of nursing (DON) stated, "On a typical day [LPN-A] does [processes] all admission orders." If there was an RN that double checked the orders right away "then nothing else happens and it is good to go." If there is not an RN available right away to double check the orders, then LPN-A completes the designated slip of paper indicating what order processes are left for the floor nurses to complete and brings it to the nurses station where she would expect the floor nurses to complete the second order check. - The DON stated she expected admission orders to be double checked within 24 hours of a residents admission and if a nurse was required to administer a medication prior to the double check then that nurse should verify the order with the admission orders in the resident's chart. The DON only educated LPN-A and RN-B regarding R1's Lantus error related to the initial transcription error of the clarification order directives and commented, "[I] should have went back and followed up on why it was not double checked." The DON further denied she had completed any audits or further follow up to ensure other residents received their medications as	21545		

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21545	Continued From page 8 prescribed. The DON stated R1's risk of not having received her Lantus as ordered could have resulted in hypoglycemic (low blood sugar) or hyperglycemic (high blood sugar) reactions in which, "It could have went any way for her [R1]." A policy, Medication Errors, reviewed 7/2/14, indicated "Residents of LFHS [Little Falls Health Services] will receive medication in accordance with their physician's order and in compliance with State and Federal Regulations." SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures for medication order transcription, along with medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication orders were correctly transcribed and administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		