Electronically Submitted
February 25, 2022

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

RE: CCN: 245399
Cycle Start Date: February 16, 2022

Dear Administrator:

On February 16, 2022, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 15, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 12, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 12, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 12, 2022, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 16, 2022. This prohibition is not subject to appeal. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely

will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Little Falls Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 16, 2022. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 16, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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

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 02/16/2022

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 2/14/22 through 2/16/22, a complaint survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The IJ began on 2/6/22, when it was identified R1 had eloped from the facility and was found outside in a snowbank during inclement weather. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 2/15/22 at 2:00 p.m. The immediate jeopardy removal was verified by the surveyor on 2/16/22 with an effective date for removal as 2/15/22, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 2/16/22. The following complaint was found to be SUBSTANTIATED: H5399057C (MN80767), with a deficiency cited at F689. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2022

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 3 residents (R1), who was identified as an elopement risk, and was found outside the facility in a snowbank during inclement weather, from elopement. This resulted in an immediate jeopardy (IJ) situation. The IJ began on 2/6/22, when it was identified R1 had eloped from the facility and was found outside in a snowbank during inclement weather. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 2/15/22 at 2:00 p.m. The immediate jeopardy removal was verified by the surveyor on 2/16/22 with an effective date for removal as 2/15/22, but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 689	Replaced R1 wandergaurd, care plan was reviewed and remains appropriate, educated staff on policy and procedure. All residents at risk for wandering and elopement care plans have been reviewed. There are standard orders for wander guard placement to be checked every day twice a day, on day and evening shift. We have changed the orders for wander guard function checks from once weekly to once every day and this is documented in the TAR. The elopement policy was reviewed and procedures were revised. We have performed an education with all staff in regards to our facility elopement policy and procedure. We are working with the state to get code approval to lock our two	3/8/22

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F 689	Continued From page 2 Findings include: R1's quarterly Minimal Data Set (MDS) dated 11/9/21, indicated R1 had a diagnosis of dementia and had severe cognitive impairment. Further, R1's MDS indicated R1 exhibited wandering behaviors daily and required supervision from staff while ambulating. R1's care plan dated 10/29/19, indicated R1 was at risk for safety due to wandering. Further, R1's care plan directed staff to encourage activities during highest wandering times, observe wandering, redirect, perform hourly rounds during times of increased wandering, and place soft touch call light under bed sheets on open side of the bed. In addition, care plan indicated R1 had a WanderGuard on her walker and ankle, which required staff to monitor daily. R1's physician's orders dated 5/27/21, indicated to check placement of WanderGuard on R1's ankle and walker twice daily, as well as check WanderGuard for proper functioning once weekly with machine. On 2/14/22, at 9:40 a.m. a new order was initiated to ensure proper functioning of R1's WanderGuard using machine daily during the night. Review of facility report number 346058 to the State Agency dated 2/6/22, indicated R1 was found outside sitting in the snow outside of the facility. Review of facility's five-day investigation to the SA dated 2/11/22, indicated licensed practical nurse (LPN)-A stated R1 was found sitting in a snowbank wearing pants, sweater, and socks but was not cold to touch. LPN-A escorted R1 back into the facility at 1:05 p.m. when the	F 689	back doors from the inside. This is a long term solution and will not be completed until MDH approves. Lastly, we have adjusted the frequency of the roam alert signal to the walkies/pagers throughout the facility. Once set off, the signal will alert at an increased frequency, making it easier for staff to hear and act on the alert. An elopement drill has been implemented once a week for 1 month and 2 times a month for 2 months and 1 time a quarter thereafter to ensure ongoing compliance. Audit results will be brought to the quarterly QAPI and will be reviewed for ongoing recommendations.	

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F 689	Continued From page 3	F 689		

WanderGuard alarm sounded, and LPN-A canceled the alarm at 1:06 p.m. LPN-A assessed R1 for injury and assisted with changing into dry clothing. Facility indicated the following were initiated to prevent reoccurrence to R1 which included WanderGuard on ankle was replaced immediately following the incident and WanderGuard functioning check was changed to daily rather than weekly. To protect other resident who require the use of a WanderGuard the facility implemented the following interventions which included tested all doors for proper functioning, list of residents at risk were placed at the nursing dietary and activities stations, facility made contact with WanderGuard vendor to assure system is properly functioning, and education was completed with dietary staff concerning the procedure of responding to the WanderGuard alarm.

Review of WanderGuard alarm report dated 2/10/22, indicated on 2/6/22 R1's WanderGuard alarmed at 12:56 p.m. and was canceled at 12:57 p.m. R1's WanderGuard alarmed again at 1:05 p.m. and was canceled at 1:06 p.m. when R1 escorted back into the facility.

Based on the weather history for Little Falls, MN on accuweather.com indicated the temperature range on 2/6/22 (day of R1's elopement) was a low of negative seven degrees to a high of 18 degrees Fahrenheit.

On 2/14/22, at 1:18 p.m. R1 was observed sitting at a table in the commons area on the Maple pod. R1 did not exhibit any wandering behavior at this time and a WanderGuard bracelet was attached to R1's walker and on her ankle.

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F 689	Continued From page 4	F 689		

On 2/14/22, at 12:28 p.m. LPN-A indicated she was R1's nurse on 2/6/22, when the incident occurred. LPN-A indicated R1 was very busy that day walking from pod to pod. Further, LPN-A indicated R1 exited the facility through the employee door by the garbage and R1 had been observed trying to go down that hallway in the past. LPN-A confirmed she did not hear the alarm system sound before R1 was found outside but it did alarm on the way back into the facility. In addition, LPN indicated there had been no further education provided since the incident.

On 2/14/22, at 12:45 p.m. dietary cook (DC)-A indicated she saw R1 on the ground outside and then alerted staff for assistance. DC-A confirmed she did not hear the WanderGuard alarm sounding.

On 2/14/22, at 12:57 p.m. dietary aide (DA)-A indicated as he returned to the dining room on 2/6/22, he saw R1's walker outside the window and saw her in the snow. DA-A confirmed he did not hear the alarm system at that time but indicated he has observed other dietary staff deactivate the alarm in the past.

On 2/14/22, at 1:34 p.m. registered nurse (RN)-A indicated she was aware of R1's incident that occurred but confirmed since the incident she has not received any additional education regarding the facility's elopement procedure or other interventions to prevent reoccurrence.

On 2/14/22, at 3:17 p.m. Administrator indicated he was made aware of the incident on 2/6/22, by the Director of Nursing (DON) at approximately 1:11 p.m. Administrator indicated during the internal investigation he interviewed all dietary

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F 689	Continued From page 5	F 689		

staff who were working on 2/6/22, to ensure none of the staff shut off the alarm prior to someone responding and ensured there was no resident elopement. All dietary staff denied shutting off the alarm and through further investigation and interviews staff reported no alarm was heard at this time. Administrator confirmed he did not interview all the nursing staff on the day of the incident and there was no additional education provided other than to the dietary department. Administrator indicated after the investigation was completed the root cause was determined to be the alarm system did sound however someone did turn it off according to the log. When asked about following the facility's policy on Elopement and monitoring the functioning daily, Administrator confirmed the facility policy indicated resident WanderGuards would be tested daily and the facility (previous to R1's elopement) was not following the policy as they were monitoring the WanderGuard functioning weekly.

Review of R1's treatment record indicate WanderGuard Protocol to ensure proper functioning of the WanderGuard of one time per day was initiated on 2/14/22 (after survey entrance), which was identified on the facility's five day investigation submitted to the SA as being initiated on 2/11/22.

On 2/15/22, at 8:48 a.m. when asked why the order to ensure proper WanderGuard functioning daily was implemented on 2/14/22, at 9:40 a.m. rather than on 2/11/22, as indicated in facility's investigation to the SA, DON indicated she verbally informed the health unit coordinator (HUC) to add in the order on 2/11/22. Further, DON indicated she was informed on 2/14/22, that

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F 689	Continued From page 6	F 689		

order had not been initiated yet. In addition, DON indicated she expected staff to put the new order in "immediately".

On 2/15/22, at 9:56 a.m. HUC indicated she was informed by the DON on 2/11/22, at approximately 12:00 p.m. to change the treatment order for the Wander Guard, however HUC stated, "I ran out of time to do everything I needed to on Friday before I left." Further, HUC indicated it is important to get the new orders changed as soon as possible "to be in compliance with the policy and to ensure the safety of the residents."

Review of facility policy titled Elopement revised 10/23/17, defined elopement as when a resident who is cognitively and physically impaired leaves a care center unsupervised. Further, the policy indicated nursing staff will test the WanderGuard daily for proper signaling and damage to bracelet. In addition, policy indicated designated staff will test the door units daily by passing a WanderGuard through the door sensors and opening the door. However, the policy lacks the procedure to respond to a resident who's WanderGuard is setting off the alarm system and when to deactivate the alarm.

The immediate jeopardy that began on 2/6/22 was removed on 2/15/22, and verified at 10:35 a.m. on 2/16/22 when it was verified the facility trained all staff on the following: the night shift nursing staff will test all WanderGuard devices daily to ensure they are functioning properly and the Elopement Policy which included the process for when the WanderGuard system is alarming, conducting searches to ensure all residents are accounted for, process if resident is not found in

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 02/16/2022

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 689	Continued From page 7 the building and notification of Administrator/DON/Family Representative/Doctor/law enforcement, and alarms will not be turned off until all resident with WanderGuard devices are located but noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 25, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: IV3X11

Dear Administrator:

The above facility was surveyed on February 14, 2022 through February 16, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Susie Haben, Rapid Response
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,

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