



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 3, 2023

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

RE: CCN: 245399
Cycle Start Date: September 14, 2023

Dear Administrator:

On October 30, 2023, 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.

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 3, 2023

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

Re: Reinspection Results
Event ID: 52DJ12

Dear Administrator:

On October 30, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 14, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2023

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

RE: CCN: 245399
Cycle Start Date: September 14, 2023

Dear Administrator:

On September 14, 2023, 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" and/or an "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 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 December 14, 2023 (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 March 14, 2024 (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/ltr_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.

Little Falls Care Center

September 27, 2023

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler". The signature is fluid and cursive, with the first letter of the last name being a large, stylized 'Z'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 9/13/24, through 9/14/23, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53995376C (MN00096718) with a deficiency cited at F791. In addition, deficient practice was identified related to incidental findings at F732. 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 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and	F 732			10/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/07/2023

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 732	Continued From page 1 unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure required nurse staffing information was posted daily. This had potential to affect all 56 residents, staff, and visitors who could wish to review this information. Findings include: On 9/13/23 at 11:10 a.m., after a tour of the	F 732	Little Falls Health Services was found to have failed to ensure nurse staffing information was posted timely. Inadequate practices were found under the following circumstances: the facility failed to post nursing staff postings for categories of licensed and unlicensed nurse staff directory responsible for resident care per shift. Binder located		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 732	Continued From page 2 facility, the nurse staffing information for that day was unable to be located. On 9/13/23 at 11:11 a.m., the nursing scheduler (NS)-A stated the posting was in a binder at the reception desk area. When asked to assist to locate the binder, she replied she would "print one off." On 9/13/23 at 11:15 a.m., the binder was requested from NS-A and provided. The three-ring binder was labeled on the front cover "Little Falls Care Center Daily Nursing Staffing Report." Single-day sheets of paper, which ranged from 9/12/23 through 7/3/23, were in the binder; however, the binder lacked postings for the following 20 days: 7/10/23, 7/11/23, 8/7/23, 8/12/23, 8/13/23, 8/19/23, 8/20/23, 8/25/23, 8/26/23, 8/27/23, 9/2/23, 9/3/23, 9/4/23, 9/5/23, 9/6/23, 9/7/23, 9/8/23, 9/9/23, 9/10/23, 9/13/23. When interviewed on 9/13/23 at 11:39 p.m., the director of nursing (DON) stated she lacked knowledge related to the staff posting regulations, or the reason for the postings other than to identify the type and number of nursing staff that worked each day; however, she expected the information to be posted in the binder every day by noon. She identified NS-A, who worked Monday through Friday typically 8:00 a.m. to 2:30 p.m., was responsible for this process. She was unsure who managed it when NS-A was off. She denied she performed audits which ensured the binder was updated daily. The DON verified the binder lacked the 20 missed days. During an interview on 9/13/23 at 11:52 a.m., NS-A stated she lacked knowledge related to the staff posting regulations, or the reason for the	F 732	near front entrance was updated to ensure nurse postings are accurate and updated. Education to be completed with all nursing staff to ensure new procedure of NOC shift posting staffing forms during their shift is to be completed. Policies were reviewed and no needed changes at this time. Potential of this occurring again in relation with inadequate nurse staffing postings. Designated binder was updated to ensure nurse staffing postings are updated and accurate. This binder will be monitored three time a week for 4 weeks; if clear of deficiencies, monitoring will then decrease to once a week for 4 weeks. Audits will be completed by DON or Designee, to reflect and ensure postings are completed timely and accurately. Completion date of 10/27/23.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 732	Continued From page 3 postings; however, she indicated she was responsible for the daily nurse staffing posting and was expected to update the binder daily. She "typically" tried to do this before noon. She indicated she worked Monday through Friday and was unsure who was responsible to update the binder on the weekends or when she was off. On 9/14/23 at 9:00 a.m., the Little Falls Care Center Daily Nursing Staffing Report binder was reviewed which lacked the 9/14/23 nurse staffing information posting. On 9/14/23 at 9:14 a.m., the health unit coordinator (HUC)-A verified the binder lacked the 9/14/23 posting. On 9/14/23 at 2:10 p.m., the administrator stated the daily postings were kept in a binder at the front desk in which he thought the overnight shift was responsible to place the postings in the binder. A Nursing Staff Posting policy, undated, identified the facility was to post daily staffing levels for review of residents and families. The policy directed the night nurse to count daily the number of nursing staff directly responsible for resident care related to that day's census and post the information at the start of the day in a visible area which was able to be reviewed by wheelchair residents. This posting was then to be updated as needed in response to call-ins, absences, etc. The previous days posting was to be placed in the human resources mailbox.	F 732			
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)	F 791			10/27/23

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	Continued From page 4 §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are	F 791			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023	
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	Continued From page 5 eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an emergency room (ER) dental referral for follow-up dental services was acted upon and provided for 1 of 1 resident (R1) observed to have numerous missing and broken teeth with dental pain and reported difficulty chewing. Findings include: R1's face sheet indicated R1's primary payer source was Medicaid (government funded health insurance). R1's quarterly Minimum Data Set (MDS) dated 6/27/23, identified R1 was cognitively intact and independent with personal hygiene. R1's Admission/General Observation Assessment Results dated 6/26/23, identified an assessment section labeled "Oral" which indicated R1's mouth, gums, and teeth were free of problems. R1's ER visit progress note, dated 8/20/23, identified R1 complained of upper and lower plate dental pain for a three day duration in which he was assessed to have dental tenderness, gingival swelling, dental caries (tooth decay), dental abscesses (pockets of pus), and gum lesions (sores) with multiple missing teeth consistent with pulpitis (inflammation of the dental pulp resulted from untreated caries or trauma with a principle symptom of pain). The note identified an order was provided for antibiotic therapy and			F 791	Little Falls Health Services was found to have failed to provide routine and emergency oral health services. Inadequate practices were found under the following circumstances: R1 needed a follow-up apt with dental surgeon within one week of being seen in the ER. Facility failed to schedule dental services timely in accordance with the order provided of one week timeframe. Staff was able to locate dental office within area that accepts insurance and appointment has been scheduled for a consultation. Potential of this occurring with other residents regarding inconsistency and incompleteness of the need for follow-up appointments. A binder was created to ensure monitoring of appointments was completed more timely, also allowing additional staff to know where work was left off in the case that the HUC is absent from the role. Policies were reviewed and found to be appropriate at this time, no changes needed. Education to be completed with all management to ensure understanding of dental services and facility involvement to ensure needs are met. All staff to be educated on the needs of appointments for residents and whom to contact for the need of appointments. This binder will be monitored weekly to ensure that appointments have been made as well as transportation has been arranged. Audits to be completed three		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	Continued From page 6 instructions for R1 to "Follow-up with dental surgeon within a week." A progress note, dated 8/21/23, indicated the health unit coordinator (HUC)-A looked into R1's insurance coverage for dental benefits and she was unsure which clinic R1 preferred for dental care. R1's medical provider visit progress note, dated 8/23/23, identified R1 displayed "numerous teeth that are broken off and inflamed at the gumline. He is in strong need for multiple teeth extractions." The note indicated R1 currently tried to set up an oral surgeon appointment for teeth removal; however, R1 doubted anyone would remove his teeth due to history of declined dental work related to blood thinner medication and his congestive heart failure. The medical provider informed R1 that because of his improved health it was likely dental providers would work with him again. The note identified a diagnosis of tooth pulpitis and instructions to continue the ordered antibiotic and to continue with dental follow-up for numerous dental extractions. R1's medical record was reviewed and lacked evidence the ER dental instructions were additionally acted upon or scheduled despite the instructions provided approximately three and a half weeks earlier. During interview on 9/13/23 at 1:35 p.m. nurse practitioner (NP)-A stated R1 displayed "horrible" dentition and had complaints of mouth pain in which R1 required multiple dental extractions. She indicated R1 required and ER trip in August for a dental infection and he was to see an oral surgeon for his concerns. She denied any recent	F 791	time a week for 4 weeks; if clear of deficiencies, audits will then decrease to once a week for 4 weeks. Audits will be completed by DON or designee, to reflect the need of appointments and to ensure that appointments and transportation is being completed timely. Completion date of 10/27/23.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	Continued From page 7 updates related to R1 and any additional dental concerns and was unsure if R1 went to a dental appointment yet or not. When interviewed on 9/13/23 at 1:54 p.m. R1 stated a bunch of his teeth were broken and "ripped up with holes in them." He allowed a quick visualization of his mouth in which numerous missing and broken teeth with discoloration were observed. He declined a more in-depth visual assessment and stated what was observed was "proof enough" he dealt with dental issues. R1 explained his dental issues started in 2011 in which he was unable to do anything about them as he did not have "five grand" to "get it done." He indicated his last dental visit was about three years ago and stated staff have asked him if he would like to see a dentist since his admission; however, he explained he could not see a dentist as he owed the facility over 11 thousand dollars, "so you do the math. They are going to get their money first and deal with me later." R1 stated the facility needed a referral for a dental appointment, which they had with his ER visit. He explained the paperwork indicated the dental follow-up was expected to be done within three days and no more than seven. R1 stated the morphine was the only thing which helped the pain. He felt he continued to have a dental infection and stated he often swallowed his food whole as he could not chew on either side. R1 stated he "told everybody" of his chewing concerns; however, he was informed to "gum the stuff and swallow it." R1 declined knowledge of an upcoming dental appointment; however, he stated he had spoken to HUC-A on 9/8/23 about a dental appointment. He denied any follow-up after that conversation. During interview on 9/13/23 at 2:55 p.m.	F 791			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	Continued From page 8 registered nurse (RN)-A stated she was R1's case manager. She explained that residents were questioned if they desired or needed a dental appointment quarterly in which the HUC scheduled the appointments and set up the transportation. It was important to act on these appointments to decrease risks associated with dental concerns such as chewing issues, pain, infection, etc. She stated the only reasons for a dental appointment to have scheduling concerns would be related to decisions made by the dental clinic, not the facility. RN-A denied staff updated her or that R1 reported dental concerns or trouble eating after his ER trip. In addition, R1 was free of weight loss or changes in his status related to his dental status. She expressed she was aware R1 desired an appointment within CentraCare (St. Cloud); however, he would go anywhere. She was under the assumption HUC-A worked on the appointment and was unaware there were scheduling concerns. When interviewed via telephone on 9/13/23 at 3:40 p.m. HUC-A denied knowledge of R1's dental status concerns; however, knew the ER progress notes directed he be seen by oral surgery. She stated she was "not very far with [R1's] dental appointment" and identified there was nothing she could think of to explain the lack of appointment progress. In follow-up, she explained she was out of the office more than usual due to being pulled to cover staffing call-ins, as she was also a nurse, and was busy with other appointment scheduling and additional assigned tasks. She denied she reached out to other staff to assist with R1's dental appointment scheduling despite the expectation the "team" would help cover her duties when she was pulled away. She stated she had only spoken to R1	F 791			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	Continued From page 9 once about the appointment where she questioned him on his preference for dental providers. R1 indicated he preferred a St. Cloud location. She denied she followed up on this information. She stated, in the past, the expectation was that the resident or the resident's family was responsible to check on benefit and insurance coverage in which she attempted to do what she could; however, she did not know what the loopholes were and "how to get there" despite an additional statement which indicated she had in the past reached out to county coordinators and was provided with dental clinic resources available in the active and surrounding counties. She was unsure what the facility's expectations were for appointment making timeframe's. During a subsequent interview on 9/13/23 at 4:10 p.m. NP-A denied knowledge related to R1's reported chewing concerns or any issues related to making a dental appointment. She explained she expected dental appointments to be set up as directed, or at least there should be a progress note indicating appointment scheduling concerns or conflicts and that she expected staff to update her if there were concerns related to scheduling the dental follow-up for R1 due to his increased risks and recent infection related to his teeth status. During an interview on 9/14/23 at 12:34 p.m. the director of nursing (DON) stated she was unaware of dental appointment concerns for R1. She was aware of R1's emergency room visit related to his teeth; however, not aware of any current issues. She explained she expected appointments to be made as directed for residents, especially for R1 due to his dental concerns and risk for re-infection. In addition, she	F 791			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 791	Continued From page 10 explained if appointment scheduling conflicts occurred then there should be record in the medical chart of the concerns and action(s) taken to resolve them. A policy was requested for appointment scheduling; however, none was provided.	F 791			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 27, 2023

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

Re: State Nursing Home Licensing Orders
Event ID:

Dear Administrator:

The above facility was surveyed on through 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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
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 9/13/23, through 9/14/23, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

10/07/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H53995376C (MN00096718) with a licensing order issued at 1335. 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 state form.	2 000			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
2 000	Continued From page 2	2 000		
21335	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. MN Rule 4658.0725 Subp. 3 A&B Providing Routine & Emergency Oral Health Ser Subp. 3. Emergency dental services. A. A nursing home must provide, or obtain from an outside resource, emergency dental services to meet the needs of each resident. Emergency dental services include services needed to treat: an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth; or any other problem of the oral cavity, appropriately treated by a dentist, that requires immediate attention. B. When emergency dental problems arise, a nursing home must contact a dentist within 24 hours, describe the dental problem, and document and implement the dentist's plans and orders. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an emergency room (ER) dental referral for follow-up dental services was acted upon and provided for 1 of 1 resident (R1) observed to have numerous missing and broken teeth with dental pain and reported difficulty chewing. Findings include:	21335		10/27/23
			Little Falls Health Services was found to have failed to provide routine and emergency oral health services. Inadequate practices were found under the following circumstances: R1 needed a follow-up apt with dental surgeon within one week of being seen in the ER. Facility failed to schedule dental services timely in accordance with the order provided of one	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21335	Continued From page 3 R1's face sheet indicated R1's primary payer source was Medicaid (government funded health insurance). R1's quarterly Minimum Data Set (MDS) dated 6/27/23, identified R1 was cognitively intact and independent with personal hygiene. R1's Admission/General Observation Assessment Results dated 6/26/23, identified an assessment section labeled "Oral" which indicated R1's mouth, gums, and teeth were free of problems. R1's ER visit progress note, dated 8/20/23, identified R1 complained of upper and lower plate dental pain for a three day duration in which he was assessed to have dental tenderness, gingival swelling, dental caries (tooth decay), dental abscesses (pockets of pus), and gum lesions (sores) with multiple missing teeth consistent with pulpitis (inflammation of the dental pulp resulted from untreated caries or trauma with a principle symptom of pain). The note identified an order was provided for antibiotic therapy and instructions for R1 to "Follow-up with dental surgeon within a week." A progress note, dated 8/21/23, indicated the health unit coordinator (HUC)-A looked into R1's insurance coverage for dental benefits and she was unsure which clinic R1 preferred for dental care. R1's medical provider visit progress note, dated 8/23/23, identified R1 displayed "numerous teeth that are broken off and inflamed at the gumline. He is in strong need for multiple teeth extractions." The note indicated R1 currently tried to set up an oral surgeon appointment for teeth	21335	week timeframe. Staff was able to locate dental office within area that accepts insurance and appointment has been scheduled for a consultation. Potential of this occurring with other residents regarding inconsistency and incompleteness of the need for follow-up appointments. A binder was created to ensure monitoring of appointments was completed more timely, also allowing additional staff to know where work was left off in the case that the HUC is absent from the role. Policies were reviewed and found to be appropriate at this time, no changes needed. Education to be completed with all management to ensure understanding of dental services and facility involvement to ensure needs are met. All staff to be educated on the needs of appointments for residents and whom to contact for the need of appointments. This binder will be monitored weekly to ensure that appointments have been made as well as transportation has been arranged. Audits to be completed three times a week for 4 weeks; if clear of deficiencies, audits will then decrease to once a week for 4 weeks. Audits will be completed by DON or designee, to reflect the need of appointments and to ensure that appointments and transportation is being completed timely. Completion date of 10/27/23.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21335	Continued From page 4 removal; however, R1 doubted anyone would remove his teeth due to history of declined dental work related to blood thinner medication and his congestive heart failure. The medical provider informed R1 that because of his improved health it was likely dental providers would work with him again. The note identified a diagnosis of tooth pulpitis and instructions to continue the ordered antibiotic and to continue with dental follow-up for numerous dental extractions. R1's medical record was reviewed and lacked evidence the ER dental instructions were additionally acted upon or scheduled despite the instructions provided approximately three and a half weeks earlier. During interview on 9/13/23 at 1:35 p.m. nurse practitioner (NP)-A stated R1 displayed "horrible" dentition and had complaints of mouth pain in which R1 required multiple dental extractions. She indicated R1 required and ER trip in August for a dental infection and he was to see an oral surgeon for his concerns. She denied any recent updates related to R1 and any additional dental concerns and was unsure if R1 went to a dental appointment yet or not. When interviewed on 9/13/23 at 1:54 p.m. R1 stated a bunch of his teeth were broken and "ripped up with holes in them." He allowed a quick visualization of his mouth in which numerous missing and broken teeth with discoloration were observed. He declined a more in-depth visual assessment and stated what was observed was "proof enough" he dealt with dental issues. R1 explained his dental issues started in 2011 in which he was unable to do anything about them as he did not have "five grand" to "get it done." He indicated his last dental visit was about three	21335			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21335	Continued From page 5 years ago and stated staff have asked him if he would like to see a dentist since his admission; however, he explained he could not see a dentist as he owed the facility over 11 thousand dollars, "so you do the math. They are going to get their money first and deal with me later." R1 stated the facility needed a referral for a dental appointment, which they had with his ER visit. He explained the paperwork indicated the dental follow-up was expected to be done within three days and no more than seven. R1 stated the morphine was the only thing which helped the pain. He felt he continued to have a dental infection and stated he often swallowed his food whole as he could not chew on either side. R1 stated he "told everybody" of his chewing concerns; however, he was informed to "gum the stuff and swallow it." R1 declined knowledge of an upcoming dental appointment; however, he stated he had spoken to HUC-A on 9/8/23 about a dental appointment. He denied any follow-up after that conversation. During interview on 9/13/23 at 2:55 p.m. registered nurse (RN)-A stated she was R1's case manager. She explained that residents were questioned if they desired or needed a dental appointment quarterly in which the HUC scheduled the appointments and set up the transportation. It was important to act on these appointments to decrease risks associated with dental concerns such as chewing issues, pain, infection, etc. She stated the only reasons for a dental appointment to have scheduling concerns would be related to decisions made by the dental clinic, not the facility. RN-A denied staff updated her or that R1 reported dental concerns or trouble eating after his ER trip. In addition, R1 was free of weight loss or changes in his status related to his dental status. She expressed she was aware R1 desired an appointment within CentraCare (St.	21335			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21335	Continued From page 6 Cloud); however, he would go anywhere. She was under the assumption HUC-A worked on the appointment and was unaware there were scheduling concerns. When interviewed via telephone on 9/13/23 at 3:40 p.m. HUC-A denied knowledge of R1's dental status concerns; however, knew the ER progress notes directed he be seen by oral surgery. She stated she was "not very far with [R1's] dental appointment" and identified there was nothing she could think of to explain the lack of appointment progress. In follow-up, she explained she was out of the office more than usual due to being pulled to cover staffing call-ins, as she was also a nurse, and was busy with other appointment scheduling and additional assigned tasks. She denied she reached out to other staff to assist with R1's dental appointment scheduling despite the expectation the "team" would help cover her duties when she was pulled away. She stated she had only spoken to R1 once about the appointment where she questioned him on his preference for dental providers. R1 indicated he preferred a St. Cloud location. She denied she followed up on this information. She stated, in the past, the expectation was that the resident or the resident's family was responsible to check on benefit and insurance coverage in which she attempted to do what she could; however, she did not know what the loopholes were and "how to get there" despite an additional statement which indicated she had in the past reached out to county coordinators and was provided with dental clinic resources available in the active and surrounding counties. She was unsure what the facility's expectations were for appointment making timeframe's. During a subsequent interview on 9/13/23 at 4:10	21335			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21335	Continued From page 7 p.m. NP-A denied knowledge related to R1's reported chewing concerns or any issues related to making a dental appointment. She explained she expected dental appointments to be set up as directed, or at least there should be a progress note indicating appointment scheduling concerns or conflicts and that she expected staff to update her if there were concerns related to scheduling the dental follow-up for R1 due to his increased risks and recent infection related to his teeth status. During an interview on 9/14/23 at 12:34 p.m. the director of nursing (DON) stated she was unaware of dental appointment concerns for R1. She was aware of R1's emergency room visit related to his teeth; however, not aware of any current issues. She explained she expected appointments to be made as directed for residents, especially for R1 due to his dental concerns and risk for re-infection. In addition, she explained if appointment scheduling conflicts occurred then there should be record in the medical chart of the concerns and action(s) taken to resolve them. A policy was requested for appointment scheduling; however, none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures so residents receive timely ordered and/or required dental appointments. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure residents receive dental appointments as ordered and/or required. TIME PERIOD FOR CORRECTION: Twenty One	21335			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2023
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
21335	Continued From page 8 (21) days	21335			