Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 23, 2024

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

RE: CCN: 245399
Cycle Start Date: July 26, 2024

Dear Administrator:

On August 22, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 23, 2024

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

Re: Reinspection Results
Event ID: 0V3K12

Dear Administrator:

On August 22, 2024 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 July 26, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 2, 2024

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

RE: CCN: 245399
Cycle Start Date: July 26, 2024

Dear Administrator:

On July 26, 2024, a 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.

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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 October 26, 2024 (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 January 26, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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 07/26/2024

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 7/25/24 through 7/26/24, 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 complaints were reviewed: H53996210C (MN00105142) An unrelated deficiency was issued at F686. 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		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		8/20/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/12/2024

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 686	Continued From page 1	F 686		

Based on observation, interview, and document review, the facility failed to follow physician orders for pressure ulcer care, and failed to follow infection control practices during a dressing change for 1 of 3 residents (R1) reviewed for pressure ulcers.

Findings include:

Definitions of pressure ulcer types according to National Pressure Ulcer Advisory Panel (NPUAP):

Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (non-viable usually moist tissue that can be soft and stringy in texture) and/or eschar (dead or devitalized tissue that is usually black and may appear scab-like) may be visible but does not obscure the depth of the tissue loss. Undermining and tunneling may occur. Fascia (connective tissues), muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound, it is an unstageable pressure ulcer.

Stage 4 Pressure Ulcer: Sores that extend below the subcutaneous fat in deep tissues including muscle, tendons, ligaments, cartilage, or bone. This stage presents a high risk of infection.

Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a

F686 – Treatment/Services to Prevent/Heal Pressure Ulcer

Facility failed to follow physician orders for pressure ulcer care and failed to follow proper infection control practices, hand hygiene, during a dressing change for R1. Hand Hygiene Policy to be reviewed with staff during monthly nurses meeting 8/13/24 as well as completion of hand hygiene audits for all direct care staff. Potential for other residents to be effected; orders to be reviewed for all residents currently receiving care for a pressure ulcer. Orders to be typed on a colored piece of paper and displayed within resident's room for direction of proper wound care; RN Case Managers to audit these and adjust upon the need. RN that failed to complete proper wound care and failed to provide adequate hand hygiene will have education as well as competency completed; education and competency to be completed by 8/20/24 by DON. Wound dressing audits will be completed as well as hand hygiene audits during wound care to ensure that facility remains compliant. Audits will be conducted by DON and/or designee 3x/week for 3 weeks, 2x/week for 2 weeks and then weekly for 3 weeks. Findings will be brought to QAPI for further review. Completion date of 8/20/24.

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F 686	Continued From page 2 Stage 3 or Stage 4 pressure ulcer will be revealed. R1's Face Sheet dated 7/25/24 indicated R1 had diagnoses of peripheral vascular disease, quadriplegia, and spinal stenosis. R1's significant change Minimum Data Set (MDS) dated 5/13/24, indicated R1 was cognitively intact and fully dependent on staff for activities of daily living (ADLs). R1's quarterly MDS dated 5/13/24 indicated R1 had one Stage 4 pressure ulcer. R1's Integrated Wound Care document dated 7/23/24, indicated a Stage 4 sacral pressure ulcer measuring 6.5 centimeters (cm) by 12.5cm and 1.8cm in depth, undermining (destruction of tissue extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface.) from 11 to 3 o'clock was 4.1cm in depth. The Stage 4 sacral pressure ulcer had heavy purulent drainage (product of inflammation that contains pus), mild odor, bone exposed, had 90% granulated (connective tissue) and 10% slough (non-viable yellow, tan, gray, green or brown tissue) on wound base. The document indicated an unstageable left buttock pressure ulcer measuring 9cm by 8cm and 3cm in depth, undermining from 12 to 3 o'clock was 5cm in depth. The unstageable left buttock pressure ulcer had heavy serosanguinous (a mixture of clear serous fluid and blood), tendon and bone exposed, had 10% necrotic (dead tissue) and 50% slough on wound base. The document indicated a Stage 3 right buttock pressure ulcer measuring 6.3cm by 4.5cm and 1.2cm in depth, undermining from 10 to 4 o'clock was 4.5cm in depth. The stage 3 right buttock ulcer had heavy serosanguinous drainage,	F 686		

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LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST** **LITTLE FALLS, MN 56345**

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F 686	Continued From page 3 50% slough, 10% granulation, and 40% necrotic tissue on wound bed. The document had a note section that indicated a discussion was had with R1 about the continuous wound deterioration, and the likely outcome of continued wound deterioration. R1's Wound Care Order as ordered by the nurse practitioner (NP)-A on 7/23/24 directed for sacral and left buttock pressure ulcer: cleanse wound, apply skin prep to peri wound, cover bone with Adaptic (non-adhering wound dressing), then apply Santyl (ointment that removes dead tissue from wound) to wound bed, then calcium alginate (non-woven, absorbent dressing made from seaweed). May fluff kerlix to fill depth of wound, into fissure, and undermining areas if needed. Cover with abdominal pad dressing (ABD) and tape, change daily and as needed (PRN). Right buttock pressure ulcer: cleanse wound, apply skin prep to peri wound, apply Santyl to wound bed and calcium alginate, cover with silicone boarder dressing, change daily and PRN. R1's electronic health record (EHR) indicated both orders started on 7/25/24. On 7/25/24 at 10:24 a.m., registered nurse (RN)-A was observed providing wound care to R1. RN-A donned proper personal protective equipment (PPE). RN-A cleansed all three pressure ulcer beds with wound cleanser, then removed her soiled gloves. Without performing hand hygiene, RN-A donned clean gloves. RN-A placed Adaptic on the base of the left buttock and sacral pressure area where bone was exposed. RN-A placed calcium alginate on all three wound beds with a cotton swab. RN-A took the cotton swab and	F 686		

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F 686	Continued From page 4 packed R1's left buttock ulcer with kerlix. RN-A grabbed new kerlix and packed R1's sacral ulcer. RN-A applied ABD dressings to all three pressure ulcers and secured bandages with tape. RN-A removed her soiled gloves, and without performing hand hygiene, donned clean gloves. RN-A placed another piece of tape on R1's left buttock dressing. RN-A removed her spoiled gloves, and without performing hand hygiene, removed R1's oxygen tubing from his nose. RN-A doffed her PPE and preformed hand hygiene before exiting the room. RN-A did not put Santyl on the wound beds as ordered. On 7/25/24 at 10:51 a.m., RN-A stated it slipped her mind to perform hand hygiene between glove changes, but the expectation was to sanitize hands after removing soiled gloves. On 7/25/24 at 1:13 p.m., RN-A stated she did not follow the physician's orders for R1's dressing changes because she was "nervous." On 7/25/24 at 2:57 p.m., nurse practitioner (NP)-A stated R1's ulcers were going to happen due to R1 comorbidities and refusals to offload. If the facility was not following the physician's orders for pressure ulcer care, the integrity of the pressure ulcer is going to be compromised. She would expect the facility to follow orders. Hand hygiene and protecting the wound from unwanted bacteria was also important to healing when completing a dressing change. On 7/26/24 at 11:34 a.m., the administrator stated staff should follow care plans, orders, and to follow the hand hygiene policy.	F 686		

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F 686	Continued From page 5 The facility policy Hand Hygiene revised 5/8/17, indicated hand hygiene is to be completed before and after direct contact with a resident, if moving from a contaminated body site to a clean body site during resident care, and between glove changes. A policy on pressure ulcers was requested but not provided.	F 686		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 2, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 0V3K11

Dear Administrator:

The above facility was surveyed on July 25, 2024 through July 26, 2024 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

Sincerely,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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
	00382	A. BUILDING: ___ B. WING ___	C 07/26/2024

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2 000	Initial Comments	2 000		

*****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 7/25/24 through 7/26/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was

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2 000	Continued From page 1	2 000		

issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

The following complaint was reviewed:
H53996210C (MN00105142)
An unrelated licensing order issued at 4658.0525 Subp 3.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00382	A. BUILDING: ______ B. WING ______	C 07/26/2024

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

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2 000	Continued From page 2 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow physician orders	2 900	2900 – Treatment/Services to Prevent/Heal Pressure Ulcer	8/20/24

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2 900	Continued From page 3 for pressure ulcer care, and failed to follow infection control practices during a dressing change for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: Definitions of pressure ulcer types according to National Pressure Ulcer Advisory Panel (NPUAP): Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (non-viable usually moist tissue that can be soft and stringy in texture) and/or eschar (dead or devitalized tissue that is usually black and may appear scab-like) may be visible but does not obscure the depth of the tissue loss. Undermining and tunneling may occur. Fascia (connective tissues), muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound, it is an unstageable pressure ulcer. Stage 4 Pressure Ulcer: Sores that extend below the subcutaneous fat in deep tissues including muscle, tendons, ligaments, cartilage, or bone. This stage presents a high risk of infection. Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. R1's Face Sheet dated 7/25/24 indicated R1 had	2 900	Facility failed to follow physician orders for pressure ulcer care and failed to follow proper infection control practices, hand hygiene, during a dressing change for R1. Hand Hygiene Policy to be reviewed with staff during monthly nurses meeting 8/13/24 as well as completion of hand hygiene audits for all direct care staff. Potential for other residents to be effected; orders to be reviewed for all residents currently receiving care for a pressure ulcer. Orders to be typed on a colored piece of paper and displayed within resident’s room for direction of proper wound care; RN Case Managers to audit these and adjust upon the need. RN that failed to complete proper wound care and failed to provide adequate hand hygiene will have education as well as competency completed; education and competency to be completed by 8/20/24 by DON. Wound dressing audits will be completed as well as hand hygiene audits during wound care to ensure that facility remains compliant. Audits will be conducted by DON and/or designee 3x/week for 3 weeks, 2x/week for 2 weeks and then weekly for 3 weeks. Findings will be brought to QAPI for further review. Completion date of 8/20/24.	

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diagnoses of peripheral vascular disease, quadriplegia, and spinal stenosis.

R1's significant change Minimum Data Set (MDS) dated 5/13/24, indicated R1 was cognitively intact and fully dependent on staff for activities of daily living (ADLs). R1's quarterly MDS dated 5/13/24 indicated R1 had one Stage 4 pressure ulcer.

R1's Integrated Wound Care document dated 7/23/24, indicated a Stage 4 sacral pressure ulcer measuring 6.5 centimeters (cm) by 12.5cm and 1.8cm in depth, undermining (destruction of tissue extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface.) from 11 to 3 o'clock was 4.1cm in depth. The Stage 4 sacral pressure ulcer had heavy purulent drainage (product of inflammation that contains pus), mild odor, bone exposed, had 90% granulated (connective tissue) and 10% slough (non-viable yellow, tan, gray, green or brown tissue) on wound base. The document indicated an unstageable left buttock pressure ulcer measuring 9cm by 8cm and 3cm in depth, undermining from 12 to 3 o'clock was 5cm in depth. The unstageable left buttock pressure ulcer had heavy serosanguinous (a mixture of clear serous fluid and blood), tendon and bone exposed, had 10% necrotic (dead tissue) and 50% slough on wound base. The document indicated a Stage 3 right buttock pressure ulcer measuring 6.3cm by 4.5cm and 1.2cm in depth, undermining from 10 to 4 o'clock was 4.5cm in depth. The stage 3 right buttock ulcer had heavy serosanguinous drainage, 50% slough, 10% granulation, and 40% necrotic tissue on wound bed. The document had a note section that indicated a discussion was had with R1 about the continuous wound deterioration, and

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the likely outcome of continued wound deterioration.

R1's Wound Care Order as ordered by the nurse practitioner (NP)-A on 7/23/24 directed for sacral and left buttock pressure ulcer: cleanse wound, apply skin prep to peri wound, cover bone with Adaptic (non-adhering wound dressing), then apply Santyl (ointment that removes dead tissue from wound) to wound bed, then calcium alginate (non-woven, absorbent dressing made from seaweed). May fluff kerlix to fill depth of wound, into fissure, and undermining areas if needed. Cover with abdominal pad dressing (ABD) and tape, change daily and as needed (PRN). Right buttock pressure ulcer: cleanse wound, apply skin prep to peri wound, apply Santyl to wound bed and calcium alginate, cover with silicone boarder dressing, change daily and PRN. R1's electronic health record (EHR) indicated both orders started on 7/25/24.

On 7/25/24 at 10:24 a.m., registered nurse (RN)-A was observed providing wound care to R1. RN-A donned proper personal protective equipment (PPE). RN-A cleansed all three pressure ulcer beds with wound cleanser, then removed her soiled gloves. Without performing hand hygiene, RN-A donned clean gloves. RN-A placed Adaptic on the base of the left buttock and sacral pressure area where bone was exposed. RN-A placed calcium alginate on all three wound beds with a cotton swab. RN-A took the cotton swab and packed R1's left buttock ulcer with kerlix. RN-A grabbed new kerlix and packed R1's sacral ulcer. RN-A applied ABD dressings to all three pressure ulcers and secured bandages with tape. RN-A removed her soiled gloves, and without performing

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hand hygiene, donned clean gloves. RN-A placed another piece of tape on R1's left buttock dressing. RN-A removed her spoiled gloves, and without performing hand hygiene, removed R1's oxygen tubing from his nose. RN-A doffed her PPE and preformed hand hygiene before exiting the room. RN-A did not put Santyl on the wound beds as ordered.

On 7/25/24 at 10:51 a.m., RN-A stated it slipped her mind to perform hand hygiene between glove changes, but the expectation was to sanitize hands after removing soiled gloves.

On 7/25/24 at 1:13 p.m., RN-A stated she did not follow the physician's orders for R1's dressing changes because she was "nervous."

On 7/25/24 at 2:57 p.m., nurse practitioner (NP)-A stated R1's ulcers were going to happen due to R1 comorbidities and refusals to offload. If the facility was not following the physician's orders for pressure ulcer care, the integrity of the pressure ulcer is going to be compromised. She would expect the facility to follow orders. Hand hygiene and protecting the wound from unwanted bacteria was also important to healing when completing a dressing change.

On 7/26/24 at 11:34 a.m., the administrator stated staff should follow care plans, orders, and to follow the hand hygiene policy.

The facility policy Hand Hygiene revised 5/8/17, indicated hand hygiene is to be completed before and after direct contact with a resident, if moving from a contaminated body site to a clean body site during resident care, and between glove changes.

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2 900	Continued From page 7 A policy on pressure ulcers was requested but not provided. SUGGESTED METHOD OF CORRECTION: The DON or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		