



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
October 4, 2024

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

RE: CCN: 245399  
Cycle Start Date: August 23, 2024

Dear Administrator:

On September 20, 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,

A handwritten signature in black ink that reads '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](mailto:Kamala.Fiske-Downing@state.mn.us)



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October 4, 2024

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

Re: Reinspection Results  
Event ID: 3GUV12

Dear Administrator:

On September 20, 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 August 23, 2024. 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 that reads '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](mailto:Kamala.Fiske-Downing@state.mn.us)



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September 4, 2024

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

RE: CCN: 245399  
Cycle Start Date: August 23, 2024

Dear Administrator:

On August 23, 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

Little Falls Care Center

September 4, 2024

Page 2

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, Regional Operations Supervisor, Rapid Response

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: [susie.haben@state.mn.us](mailto: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 November 23, 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 February 23, 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/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_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](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 4, 2024

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a loop at the end of the last name.

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](mailto:Kamala.Fiske-Downing@state.mn.us)



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Electronically delivered  
September 4, 2024

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

Re: State Nursing Home Licensing Orders  
Event ID: 3GUV11

Dear Administrator:

The above facility was surveyed on August 22, 2024 through August 23, 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](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.

Little Falls Care Center

September 4, 2024

Page 2

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, Regional Operations Supervisor, Rapid Response**

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: [susie.haben@state.mn.us](mailto: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.

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](mailto:Kamala.Fiske-Downing@state.mn.us)

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

PRINTED: 09/18/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245399</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/23/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE FALLS CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  On 8/22/24 through 8/23/24, 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 complaint was reviewed: H53997181C (MN00105832).  As a result of the investigation, a deficiency was cited at F580.  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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		9/18/24	

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

TITLE

(X6) DATE

Electronically Signed

09/13/2024

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.

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

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NAME OF PROVIDER OR SUPPLIER  <b>LITTLE FALLS CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 FIRST AVENUE NORTHEAST</b> <b>LITTLE FALLS, MN 56345</b>		
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F 580	<p>Continued From page 1</p> <p>physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to</p>	F 580		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>LITTLE FALLS CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345</b>		
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F 580	<p>Continued From page 2</p> <p>room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to ensure the provider and resident representative were notified of a fall for 1 of 3 residents (R2) reviewed.</p> <p>Findings include:</p> <p>R2's admission Minimal Data Set (MDS), undated as it was still in progress, indicated R2 had diagnoses which included type 2 diabetes and hypertension.</p> <p>R2's progress note dated 8/16/24, indicated R2 had rolled out of bed at 11:30 p.m. on 8/15/24, trying to get to the fridge, rolled onto the floor looking for kids. Staff implemented a low bed and fall mat was in place as well as safety checks every 1-2 hours. However, R2's record lacked evidence the provider or resident representative was notified of the fall.</p> <p>On 8/23/24 at 11:26 a.m., registered nurse (RN)-A stated staff would be expected to notify the resident's provider and representative "right away" following a fall.</p> <p>On 8/23/24 at 11:51 a.m., director of nursing (DON) stated staff were expected to notify the resident's representative and the provider as soon as possible, following a fall. DON stated follow up with staff regarding R2's fall that occurred on 8/15/24, revealed the floor nurse's night was "chaotic" and she forgot to complete an incident report for the fall and notify the provider and resident representative.</p>	F 580	<p>Little Falls Health Services was found to have failed to ensure the provider and resident representative were notified of a fall for resident R2.</p> <p>Inadequate practices were found under the following circumstances; R2 shows to have had a fall on 8/16/24 per a progress note. Staff implemented immediate interventions for future prevention of falls but failed to report this incident to provider and family representative. R2's family and provider have been updated on the fall as of 8/23/24 at 0915.</p> <p>All residents with falls have a potential to be affected by this deficient practice. Nurse cart binders to be updated to reflect fall checklist that indicates the needs of actions to be taken with any fall occurrence. Checklists will be returned to the RN Case Managers once completed to ensure adequate practices were followed. Fall incidents to be reviewed back to August 23rd, 2024 to ensure that proper notifications were completed; education to be completed with staff that were found deficient.</p> <p>Education was completed during monthly nurse meeting on 9/10/24 as well as review of "Accident/Incident" policy (CCEP.QC.002 Accident/Incident) educating nursing staff of section B) "Notification of a Family Member or Responsible Party: When a resident suffers an injury due to an accident/incident, family or the</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>LITTLE FALLS CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 FIRST AVENUE NORTHEAST</b> <b>LITTLE FALLS, MN 56345</b>		
(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 580	Continued From page 3  Review of facility policy titled Accident/Incident dated 1/18/18, indicated notification of a family member or responsible party when a resident suffers an injury due to an accident/incident, family or the responsible party would be notified immediately. If there was no injury as a result of the accident/incident family or responsible party would be notified within a reasonable time frame. Family or responsible party would be advised of a fall. In addition, the physician would be notified immediately whenever an injury occurs and for all other events within a reasonable timeframe.	F 580	responsible party will be notified immediately. If there is no injury as a result of the accident/incident, family or responsible party will be notified within a reasonable time frame," as well as section C) Physician Notification: The physician will be notified immediately whenever an injury occurs or medical treatment is required. The physician will be notified for all other events within a reasonable timeframe, using care center procedure, as agreed upon by the Director of Nursing and the Medical Director."  DON or designee to complete audits 3x / week for 3 weeks, then 2x / week for 2 weeks, then weekly for 4 weeks. Audits to reflect review of all progress notes and fall incidents to ensure that notification was completed timely. If found that staff are deficient, education will be completed by DON. Results of audits will be brought to QAPI for review for further recommendations for monitoring. Completion date of 9/18/24.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00382</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/23/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LITTLE FALLS CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345</b>
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2 000	<p><b>Initial Comments</b></p> <p><b>*****ATTENTION*****</b></p> <p><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> On 8/22/24 through 8/23/24, 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 issued. Please indicate in your electronic plan of correction you have reviewed these orders and</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>09/13/24</b>
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00382</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/23/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LITTLE FALLS CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345</b>
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(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
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2 000	<p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaint was reviewed: H53997181C (MN00105832).</p> <p>As a result of the investigation, a licensing order was issued at 1830.</p> <p>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.</p> <p>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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a> 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</p>	2 000		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00382</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/23/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LITTLE FALLS CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345</b>
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2 000	Continued From page 2  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		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights  Subd. 10. Participation in planning treatment; notification of family members.  (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason	21830		9/18/24

Minnesota Department of Health

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21830	<p>Continued From page 3</p> <p>to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:</p> <p>(1) examining the personal effects of the resident;</p> <p>(2) examining the medical records of the resident in the possession of the facility;</p> <p>(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and</p> <p>(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.</p> <p>(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident</p>	21830		
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21830	<p>Continued From page 4</p> <p>and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the provider and resident representative were notified of a fall for 1 of 3 residents (R2) reviewed.</p> <p>Findings include:</p> <p>R2's admission Minimal Data Set (MDS), undated as it was still in progress, indicated R2 had diagnoses which included type 2 diabetes and hypertension.</p> <p>R2's progress note dated 8/16/24, indicated R2 had rolled out of bed at 11:30 p.m. on 8/15/24, trying to get to the fridge, rolled onto the floor</p>	21830	<p>Little Falls Health Services was found to have failed to ensure the provider and resident representative were notified of a fall for resident R2.</p> <p>Inadequate practices were found under the following circumstances; R2 shows to have had a fall on 8/16/24 per a progress note. Staff implemented immediate interventions for future prevention of falls but failed to report this incident to provider and family representative. R2's family and provider have been updated on the fall as of 8/23/24 at 0915.</p> <p>All residents with falls have a potential to be affected by this deficient practice.</p>	
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21830	<p>Continued From page 5</p> <p>looking for kids. Staff implemented a low bed and fall mat was in place as well as safety checks every 1-2 hours. However, R2's record lacked evidence the provider or resident representative was notified of the fall.</p> <p>On 8/23/24 at 11:26 a.m., registered nurse (RN)-A stated staff would be expected to notify the resident's provider and representative "right away" following a fall.</p> <p>On 8/23/24 at 11:51 a.m., director of nursing (DON) stated staff were expected to notify the resident's representative and the provider as soon as possible, following a fall. DON stated follow up with staff regarding R2's fall that occurred on 8/15/24, revealed the floor nurse's night was "chaotic" and she forgot to complete an incident report for the fall and notify the provider and resident representative.</p> <p>Review of facility policy titled Accident/Incident dated 1/18/18, indicated notification of a family member or responsible party when a resident suffers an injury due to an accident/incident, family or the responsible party would be notified immediately. If there was no injury as a result of the accident/incident family or responsible party would be notified within a reasonable time frame. Family or responsible party would be advised of a fall. In addition, the physician would be notified immediately whenever an injury occurs and for all other events within a reasonable timeframe.</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b> The administrator, director of nursing (DON), or designee could develop and implement measure to ensure timely notification to the physician and resident representative. The facility could update policies and procedures, educate staff on these</p>	21830	<p>Nurse cart binders to be updated to reflect fall checklist that indicates the needs of actions to be taken with any fall occurrence. Checklists will be returned to the RN Case Managers once completed to ensure adequate practices were followed. Fall incidents to be reviewed back to August 23rd, 2024 to ensure that proper notifications were completed; education to be completed with staff that were found deficient.</p> <p>Education was completed during monthly nurse meeting on 9/10/24 as well as review of "Accident/Incident" policy (CCEP.QC.002 Accident/Incident) educating nursing staff of section B) "Notification of a Family Member or Responsible Party: When a resident suffers an injury due to an accident/incident, family or the responsible party will be notified immediately. If there is no injury as a result of the accident/incident, family or responsible party will be notified within a reasonable time frame," as well as section C) Physician Notification: The physician will be notified immediately whenever an injury occurs or medical treatment is required. The physician will be notified for all other events within a reasonable timeframe, using care center procedure, as agreed upon by the Director of Nursing and the Medical Director."</p> <p>DON or designee to complete audits 3x / week for 3 weeks, then 2x / week for 2 weeks, then weekly for 4 weeks. Audits to reflect review of all progress notes and fall incidents to ensure that notification was completed timely. If found that staff are</p>	
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21830	<p>Continued From page 6</p> <p>changes, and audit periodically to ensure the needs of resident(s) are maintained. The facility should perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21830	<p>deficient, education will be completed by DON. Results of audits will be brought to QAPI for review for further recommendations for monitoring. Completion date of 9/18/24.</p>	