DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 19, 2022

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

RE: CCN: 245399
Cycle Start Date: June 30, 2022

Dear Administrator:

On August 9, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 19, 2022

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

Re: Reinspection Results
Event ID: GJKX12

Dear Administrator:

On August 9, 2022 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 9, 2022. 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
July 13, 2022

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

RE: CCN: 245399
Cycle Start Date: June 30, 2022

Dear Administrator:

On June 30, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 September 30, 2022 (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 December 30, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	C 06/30/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On June 27, 2022 through June 30, 2022, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On June 27, 2022 through June 30, 2022, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5399061C (MN00080959), with a deficiency cited at (F761). The following complaints were found to be UNSUBSTANTIATED: H5399060C/MN00082324 H53992663C/MN00083248 H53992662C/MN00084091 H53992676C/MN00084446	F 000		

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

Electronically Signed | 07/25/2022

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

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F 000	Continued From page 1 H5399059C/MN00082747 H5399058C/MN00074323 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 substantial compliance with the regulations has been attained.	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		8/3/22

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F 761	Continued From page 2 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure narcotic and controlled substance cabinet in the COVID area was properly secured to prevent medication diversion for 2 of 2 residents (R4 and R205) whose narcotic and/or controlled medications were stored in the cabinet. Findings include: On 6/29/22 at 1:45 a.m. When interviewed trained medication aid (TMA)- A stated narcotic and controlled medications were stored in the steel cabinet bolted to the wall in the clean room for residents residing in the COVID unit. A gray steel cabinet was observed secured to the wall, the cabinet had 2 doors which had separate locks and different keys to open each door. Cabinet was observed to have both doors open with the keys attached to a lanyard hanging in the lock of the second door. TMA was located in the room with the cabinet and was able to view the cabinet while in the room. On 6/30/22 at 10:47 a.m. the narcotic and controlled medication cabinet was observed in the COVID unit to have both doors open, with keys on lanyard hanging from second door lock, there was no staff in the room with the unlocked cabinet. During continuous observation, no staff	F 761	Little Falls Health Services was found to have scheduled 2 medications not properly stored behind double lock. R4 and R205 were found to have a controlled substance present within double locked cabinet. Controlled substances were confirmed in place and counted with TMA and State Surveyor upon finding; DON completed education at this time to TMA staff. Potential of this occurring to other residents with presence of controlled substances. DON or designee to complete audits to ensure medications remain in appropriate locations and behind double locks. Audits to confirm medications are accounted for and that locks remain in appropriate working order. Audits to be completed by 7/21/22. Policy was reviewed; showing no changes to be needed. Education to be provided to nursing staff in regards to double locking and securing Scheduled 2 narcotics and controlled substances. DON and/or designee to complete audits 3x/week for four weeks, two times a week for four weeks and then once a week for four weeks. Audits to reflect proper storage and confinement for scheduled 2 narcotics and controlled substances.	

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F 761	Continued From page 3 secured the narcotics until TMA-A returned at 11:04 a.m. On 6/30/22 at 11:04 a.m. TMA-A stated during interview she had left the room when R4 was attempting to enter the clean room so Ativan (medication used to treat anxiety) was removed from the cabinet to administer to R4, TMA-A stated had put on a gloves and a gown to quickly get R4 from the clean room, now that she had returned to the room she could secure the cabinet doors. TMA-A was observed locking the cabinet then placed the keys on top of the cabinet. When interviewed TMA-A stated there was a potential for a person to enter the room and remove the medications when cabinet not was secured. On 6/30/22 at 11:12 a.m. registered nurse (RN)-A stated the expectation was narcotics and controlled medications were to be stored behind a double lock, if left unlocked staff or residents could steal and/or consume the medications. On 6/30/22 at 12:03 p.m. director of nursing (DON) stated narcotics were stored under double lock, when medication were removed were to be secured by double lock immediately, otherwise anyone could remove the medications. Facility Policy dated 7/18/16 identified controlled substances shall be double locked at all times in a separately locked compartment permanently affixed to the physical plant or medication cart. The key shall be the responsibility of the charge nurse or TMA and will be on his/her person at all times.	F 761	Findings to be brought to QAPI for further recommendations for on-going monitoring.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		8/3/22

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F 804	Continued From page 4 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 3 of 3 residents (R5, R39, and R52) reviewed for food. Findings include: On 6/27/22, at 2:33 p.m. R5 stated the food was always served cold and tasted horrible. On 6/28/22, at 3:30 p.m. R39 stated, the food had been fairly hot until recently when there had been a few times the food was not always warm when it reached her room. On 6/29/22, at 7:33 a.m. food service for the breakfast meal began on the units. On 6/29/22, at 7:51 a.m. R5 stated his breakfast was cold this morning. R5 was sitting in a chair in his room with a plate of eggs, bacon, and toast sitting on a tray in from of him about 25 percent of the food was eaten. R5 stated it was unappetizing when served cold.	F 804	Upon receiving CMS 2567 report on 7/14/22 regarding food holding and serving temperatures, dietitian will implement training on proper hot and cold holding food items. Hot foods need to be held at 140 degrees F or greater and cold foods need to be held at 41 degrees F or lower. Dietary Manager will conduct daily audits ongoing. The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring. On 7/15/22, dietitian wrote LFHS In-Room Dining Policy. The policy will be reviewed with all dietary staff on 7/25/22 as well as any team member that deliver meals to rooms. Room trays quantity will be limited and set up on carts in sequential order to ensure food temperature quality for residents. To monitor resident satisfaction and food temperatures for room trays, test meal/tray audit will be implemented 1 time per week for a month; followed by 2 times per month; 1 time per month ongoing to ensure continuum of quality and safe	

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F 804	Continued From page 5 On 6/29/22, at 7:55 a.m. R52 stated her food was not very warm. R52 was sitting in her room with eggs and hot cereal on a tray in front of her. Only a few bites of hot cereal were eaten, and stated it was due to the temperature. On 6/29/22, at 8:09 a.m. a tray was requested from the steam table as the last of the trays were being dished up and was tested served to surveyor at 8:23 as the last of the trays were sent out. The meal included oatmeal, eggs, and sausage. The sausage and oatmeal were barely warm and the eggs were neither warm or palatable. The plated eggs temperature was 105 degrees Fahrenheit (F), the sausage was at 105 degrees F and the oatmeal was at 100 degrees F. Dietary aide (DA-A) indicated the oatmeal, eggs, and sausage were not warm enough and that the expectation would have been to reheat any food that is not warm enough, or to get new food. On 6/29/22, at 8:44 a.m. the head cook (HC) indicated it had been difficult to keep eggs warm but that the sausage should always be served at 165 degrees F. HC further indicated his expectation would have been for the sausage to be at least 165 degrees F or it should have been reheated or discarded.. On 6/29/22, at 8:56 a.m. the administrator stated both dining rooms have been shut down related to COVID-19 outbreak but they were planning on reopening within the next week. Administrator further stated the facility had been without a dietary manager (DM) for about a month but the dietician had been coming to the facility a few days a week and is available by phone or email. Administrator confirmed his expectation would be	F 804	service. The monitoring results will be reported at the quarterly QAPI for review and recommendation for ongoing auditing.	

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F 804	Continued From page 6 that hot food was served at least 140 deg F with the exception of meat being 165 deg F. A facility policy titled Food Temperatures dated 4/20/22, indicated all hot food items must be served at a temperature of at least 140 deg F. The policy further indicated temperatures should be taken periodically to ensure hot foods stay above 140 deg F.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishes were properly sanitized when their hot water temperature dishwasher failed to reach proper temperature and utilized a sanitizer spray, but	F 812	On 6/24/2022, upon awareness of inadequate dishwasher rinse temperatures, the dietary department was instructed to use quaternary disinfectant according to label directions to disinfect all	8/3/22

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F 812	Continued From page 7 instead of air drying the dishes, used the unsanitary practice of drying them with a towel. This had to the potential to affect all 52 current residents who were served food on the dishes. Findings include: On 6/27/22, at 1:23 p.m. during an initial tour of the kitchen dietary aide (DA)-A was observed washing dishes using a CMA brand, high temperature dishwasher. The thermometer on the wash cycle was registered at 110 deg F (degrees Fahrenheit), and the rinse temperature was 130 deg F. DA-A stated any time the rinse was below 180 the dishes should have been sprayed with sanitizer. DA-A proceeded to spray 3 plates and 2 glasses with sanitizer spay and then towel dried the dishes. During an interview on 6/27/22, at 1:32 p.m Cook-A stated she was not sure how long the dishwasher had not been working properly, but they were to spray the dishes with sanitizer spray and leave them out to air dry. Located near the dishwasher on the wall was a sign untitled, undated, which read, "If dishwasher is below 180 degrees you must use spray sanitizer on all eating surfaces of dishes, in addition, note on temperature log you sprayed sanitizer." In addition, there was a form used to record dishwasher temperatures. The form had a row for each day of the month and columns which identified the date and places to document wash and rinse temperature for breakfast, lunch, and supper. The form also included an area to document action taken. Review of the form from 6/1/22, - 6/24/22, indicated the form lacked documentation of wash and rinse temperatures at	F 812	of the silverware, cups, tableware, and cookware. The disinfecting protocol and alerting maintenance immediately is in place and to be utilized anytime dish machine rinse temperatures do not reach 160 degrees F using plate temperature disc or 180 degrees F using dish machine gauge. Dietitian educated dietary staff to test dishwasher temperature after each meal and before running dirty dishes. Staff was re-education on proper dishwasher temperatures and to use dishwasher temperature log as their guide. Dish machine temperature audits will be completed by the administrator or designee 2 times per week for 2 weeks, then 1 time per week for 1 month, then 1 time per month ongoing to ensure compliance. This will include documenting a corrective action process if dish machine temperatures are below required levels. The monitoring results will be reported at the quarterly QAPI for review and recommendations for ongoing auditing. On 7/18/22, specific High Temperature Dish Machine Guideline wall chart will be posted in kitchen near dish machine. All staff will be trained again on the washing and temperature guideline as well as corrective actions steps to take if dish machine is out of temperature. 1) Notify dietary manager immediately. In absence of dietary manager, notify maintenance director and/or administrator. 2) Follow sanitization techniques options: Spray sanitizing after dishes have gone through dish machine:	

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	245399	A. BUILDING _____ B. WING _____	C 06/30/2022

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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 812	Continued From page 8 supper on 6/6/22, and 6/7/22. further, the form lacked documentation of wash and rinse temperatures for breakfast, lunch, and supper on 6/22/22. There were a total of 67 rinse temperature entries and 25 of the 67 entries fell below the 180 deg F range. The form further lacked documentation the dishes had been sprayed with sanitizer for 23 of 25 times the rinse fell below 180 deg F. During an interview on 6/27/22, at 1:37 p.m. dietary aide (DA)-A completed a dishwasher run and stated the temperature of the rinse was 130 deg F and the process was to spray the dishes with sanitizer and towel dry. DA-A further indicated staff should have been recording the wash and rinse temperatures of the dishwasher after each meal and did not know why there were so many temperatures missing from the log. On a follow up visit to the kitchen on 6/27/22, at 4:07 p.m. DA-B ran a load of plates and glasses through the dishwasher the rinse cycle temperature read 160 deg F. DA-B sprayed the dishes with sanitizer and allowed the dishes to air dry. During an interview on 6/27/22, at 4:11 p.m. Administrator indicated he had been made aware of the problem on 6/24/22, of the dishwasher rinse temperatures not being hot enough and had been unaware of the dishwasher rinse temps falling below 180 deg F prior to that. Administrator further indicated he had talked to the dishwasher repair company on 6/24/22, and they told him how to fix it over the phone and that the dishwasher had been working last Friday. After reviewing log on the wall Administrator confirmed rinse temperatures had not reached 180 deg F	F 812	a) spray flat surface dishes with spray sanitization, then air dry. b) soak silverware, deep bowls and drinkware in tub of sanitizer, then place in rack to allow air drying. Three-sink sanitizing a)Follow instructions posted.	

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F 812	Continued From page 9 over the past weekend and there was no documentation of dished being sprayed with sanitizer for all three meals on 6/26/22. Administrator stated that if the rinse temperature fell below 180 deg F staff were expected to spray the dishes with sanitizer and allow to air dry. Administrator indicated that supper on 6/27/22, would be served using disposable plates, and dinnerware, and the dishes would be rewashed. Administrator further indicated the repair company would be out on 6/28/22 to repair the dishwasher. During an email correspondence on 6/28/22, registered dietician, (RD) indicated the dishwasher rinse temperature should have always reached 180 deg F and if not the dishes should have been sprayed with sanitizer and air dried. RD further indicated that drying with a towel could have recontaminated the surfaces. Facility infection control logs were reviewed from January 2022 to present and there was no indication of gastro-intestinal outbreaks or food-borne illness related infection. During interview on 6/28/22, at 2:05 p.m. the dishwasher service vendor (DSV) stated he was notified of the problem this morning and came out as soon as he had been able. The DSV stated the high temp rinse was not functioning so the water was only heating up to the in house water temperatures which was below 180 deg F. The DSV stated he replaced the booster and the thermostat and now the dishwasher was functioning properly. The DSV stated wash temps (temperatures) should be 160 deg F and the rinse temperatures should reach and be 180 deg F. The DSV stated it was important for the	F 812		

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F 812	Continued From page 10 facility to monitor wash and rinse temperatures, and to make sure dishware was clean and appropriately sanitized. A facility policy titled Cleaning Dishes/ Dish Machine dated 4/20/22, indicated wash temperatures should have reached 150-165 deg F and the final rinse should reach 180 deg F. The policy further indicated dishware should have been air dried and no towels should have been used on dishware.	F 812		

Electronically delivered
July 13, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: GJKX11

Dear Administrator:

The above facility was surveyed on June 27, 2022 through June 30, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00382	A. BUILDING: _____ B. WING _____	C 06/30/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 27, 2022 through June 30, 2022, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued:	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5399061C (MN00080959), with a licensing order issued at 1610/Schedule II storage AND/OR The following complaints were found to be UNSUBSTANTIATED: H5399060C/MN00082324 H53992663C/MN00083248 H53992662C/MN00084091 H53992676C/MN00084446 H5399059C/MN00082747 H5399058C/MN00074323 Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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	2 000		

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2 000	Continued From page 2 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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. 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		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		8/3/22

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21015	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishes were properly sanitized when their hot water temperature dishwasher failed to reach proper temperature and utilized a sanitizer spray, but instead of air drying the dishes, used the unsanitary practice of drying them with a towel. This had to the potential to affect all 52 current residents who were served food on the dishes. Findings include: On 6/27/22, at 1:23 p.m. during an initial tour of the kitchen dietary aide (DA)-A was observed washing dishes using a CMA brand, high temperature dishwasher. The thermometer on the wash cycle was registered at 110 deg F (degrees Fahrenheit), and the rinse temperature was 130 deg F. DA-A stated any time the rinse was below 180 the dishes should have been sprayed with sanitizer. DA-A proceeded to spray 3 plates and 2 glasses with sanitizer spay and then towel dried the dishes. During an interview on 6/27/22, at 1:32 p.m Cook-A stated she was not sure how long the dishwasher had not been working properly, but they were to spray the dishes with sanitizer spray and leave them out to air dry. Located near the dishwasher on the wall was a sign untitled, undated, which read, "If dishwasher is below 180 degrees you must use spray sanitizer on all eating surfaces of dishes, in addition, note on temperature log you sprayed sanitizer." In addition, there was a form used to record dishwasher temperatures. The form had a row for each day of the month and columns which	21015	Corrected	

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21015	Continued From page 4 identified the date and places to document wash and rinse temperature for breakfast, lunch, and supper. The form also included an area to document action taken. Review of the form from 6/1/22, - 6/24/22, indicated the form lacked documentation of wash and rinse temperatures at supper on 6/6/22, and 6/7/22. further, the form lacked documentation of wash and rinse temperatures for breakfast, lunch, and supper on 6/22/22. There were a total of 67 rinse temperature entries and 25 of the 67 entries fell below the 180 deg F range. The form further lacked documentation the dishes had been sprayed with sanitizer for 23 of 25 times the rinse fell below 180 deg F. During an interview on 6/27/22, at 1:37 p.m. dietary aide (DA)-A completed a dishwasher run and stated the temperature of the rinse was 130 deg F and the process was to spray the dishes with sanitizer and towel dry. DA-A further indicated staff should have been recording the wash and rinse temperatures of the dishwasher after each meal and did not know why there were so many temperatures missing from the log. On a follow up visit to the kitchen on 6/27/22, at 4:07 p.m. DA-B ran a load of plates and glasses through the dishwasher the rinse cycle temperature read 160 deg F. DA-B sprayed the dishes with sanitizer and allowed the dishes to air dry. During an interview on 6/27/22, at 4:11 p.m. Administrator indicated he had been made aware of the problem on 6/24/22, of the dishwasher rinse temperatures not being hot enough and had been unaware of the dishwasher rinse temps falling below 180 deg F prior to that. Administrator further indicated he had talked to the dishwasher	21015		

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21015	Continued From page 5 repair company on 6/24/22, and they told him how to fix it over the phone and that the dishwasher had been working last Friday. After reviewing log on the wall Administrator confirmed rinse temperatures had not reached 180 deg F over the past weekend and there was no documentation of dished being sprayed with sanitizer for all three meals on 6/26/22. Administrator stated that if the rinse temperature fell below 180 deg F staff were expected to spray the dishes with sanitizer and allow to air dry. Administrator indicated that supper on 6/27/22, would be served using disposable plates, and dinnerware, and the dishes would be rewashed. Administrator further indicated the repair company would be out on 6/28/22 to repair the dishwasher. During an email correspondence on 6/28/22, registered dietician, (RD) indicated the dishwasher rinse temperature should have always reached 180 deg F and if not the dishes should have been sprayed with sanitizer and air dried. RD further indicated that drying with a towel could have recontaminated the surfaces. Facility infection control logs were reviewed from January 2022 to present and there was no indication of gastro-intestinal outbreaks or food-borne illness related infection. During interview on 6/28/22, at 2:05 p.m. the dishwasher service vendor (DSV) stated he was notified of the problem this morning and came out as soon as he had been able. The DSV stated the high temp rinse was not functioning so the water was only heating up to the in house water temperatures which was below 180 deg F. The DSV stated he replaced the booster and the thermostat and now the dishwasher was	21015		

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21015	Continued From page 6 functioning properly. The DSV stated wash temps (temperatures) should be 160 deg F and the rinse temperatures should reach and be 180 deg F. The DSV stated it was important for the facility to monitor wash and rinse temperatures, and to make sure dishware was clean and appropriately sanitized. A facility policy titled Cleaning Dishes/ Dish Machine dated 4/20/22, indicated wash temperatures should have reached 150-165 deg F and the final rinse should reach 180 deg F. The policy further indicated dishware should have been air dried and no towels should have been used on dishware. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate infection control technique is maintained in the kitchen. The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade)	21025		8/3/22

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21025	Continued From page 7 or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 3 of 3 residents (R5, R39, and R52) reviewed for food. Findings include: On 6/27/22, at 2:33 p.m. R5 stated the food was always served cold and tasted horrible. On 6/28/22, at 3:30 p.m. R39 stated, the food had been fairly hot until recently when there had been a few times the food was not always warm when it reached her room. On 6/29/22, at 7:33 a.m. food service for the breakfast meal began on the units. On 6/29/22, at 7:51 a.m. R5 stated his breakfast was cold this morning. R5 was sitting in a chair in his room with a plate of eggs, bacon, and toast sitting on a tray in from of him about 25 percent of the food was eaten. R5 stated it was unappetizing when served cold. On 6/29/22, at 7:55 a.m. R52 stated her food was not very warm. R52 was sitting in her room with eggs and hot cereal on a tray in front of her. Only a few bites of hot cereal were eaten, and stated it was due to the temperature.	21025	Corrected	

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21025	Continued From page 8 On 6/29/22, at 8:09 a.m. a tray was requested from the steam table as the last of the trays were being dished up and was tested served to surveyor at 8:23 as the last of the trays were sent out. The meal included oatmeal, eggs, and sausage. The sausage and oatmeal were barely warm and the eggs were neither warm or palatable. The plated eggs temperature was 105 degrees Fahrenheit (F), the sausage was at 105 degrees F and the oatmeal was at 100 degrees F. Dietary aide (DA-A) indicated the oatmeal, eggs, and sausage were not warm enough and that the expectation would have been to reheat any food that is not warm enough, or to get new food. On 6/29/22, at 8:44 a.m. the head cook (HC) indicated it had been difficult to keep eggs warm but that the sausage should always be served at 165 degrees F. HC further indicated his expectation would have been for the sausage to be at least 165 degrees F or it should have been reheated or discarded.. On 6/29/22, at 8:56 a.m. the administrator stated both dining rooms have been shut down related to COVID-19 outbreak but they were planning on reopening within the next week. Administrator further stated the facility had been without a dietary manager (DM) for about a month but the dietician had been coming to the facility a few days a week and is available by phone or email. Administrator confirmed his expectation would be that hot food was served at least 140 deg F with the exception of meat being 165 deg F. A facility policy titled Food Temperatures dated 4/20/22, indicated all hot food items must be served at a temperature of at least 140 deg F.	21025		

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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
21025	Continued From page 9 The policy further indicated temperatures should be taken periodically to ensure hot foods stay above 140 deg F. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting registered dietitian could review and revise policies and procedures for proper testing of food temperature, and establish a plan of correction when reports of low food temps are identified. The DON or designee, along with the Registered Dieititian could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21025		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure narcotic and controlled substance cabinet in the COVID area was properly secured to prevent medication diversion for 2 of 2 residents (R4 and R205) whose narcotic and/or controlled medications were stored in the cabinet. Findings include: On 6/29/22 at 1:45 a.m. When interviewed	21610	Corrected	8/3/22

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	00382	A. BUILDING: _____ B. WING _____	C 06/30/2022

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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21610	Continued From page 10 trained medication aid (TMA)- A stated narcotic and controlled medications were stored in the steel cabinet bolted to the wall in the clean room for residents residing in the COVID unit. A gray steel cabinet was observed secured to the wall, the cabinet had 2 doors which had separate locks and different keys to open each door. Cabinet was observed to have both doors open with the keys attached to a lanyard hanging in the lock of the second door. TMA was located in the room with the cabinet and was able to view the cabinet while in the room. On 6/30/22 at 10:47 a.m. the narcotic and controlled medication cabinet was observed in the COVID unit to have both doors open, with keys on lanyard hanging from second door lock, there was no staff in the room with the unlocked cabinet. During continuous observation, no staff secured the narcotics until TMA-A returned at 11:04 a.m. On 6/30/22 at 11:04 a.m. TMA-A stated during interview she had left the room when R4 was attempting to enter the clean room so Ativan (medication used to treat anxiety) was removed from the cabinet to administer to R4, TMA-A stated had put on a gloves and a gown to quickly get R4 from the clean room, now that she had returned to the room she could secure the cabinet doors. TMA-A was observed locking the cabinet then placed the keys on top of the cabinet. When interviewed TMA-A stated there was a potential for a person to enter the room and remove the medications when cabinet not was secured. On 6/30/22 at 11:12 a.m. registered nurse (RN)-A stated the expectation was narcotics and controlled medications were to be stored behind a	21610		

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21610	Continued From page 11 double lock, if left unlocked staff or residents could steal and/or consume the medications. On 6/30/22 at 12:03 p.m. director of nursing (DON) stated narcotics were stored under double lock, when medication were removed were to be secured by double lock immediately, otherwise anyone could remove the medications. Facility Policy dated 7/18/16 identified controlled substances shall be double locked at all times in a separately locked compartment permanently affixed to the physical plant or medication cart. The key shall be the responsibility of the charge nurse or TMA and will be on his/her person at all times. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		

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	245399	A. BUILDING **03 - EAST BUILDING** B. WING _____	**06/29/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted on 06/29/2022, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Little Falls Care Center, Building 03 - East Building Addition was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/22/2022

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

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	245399	A. BUILDING **03 - EAST BUILDING** B. WING _____	**06/29/2022**

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as two buildings: Little Falls Care Center consists of two buildings separated by a 2 hour fire separation. Building 03, the East Building Addition is 1 story buildings without a basement built in 2016 and was determined to be Type II(111) construction. Building 04, the West building is a 1 story building without a basement and was determined to be Type II(111) construction. Since Building 03 was built under the 2000 edition of the National Fire Protection Association (NFPA) Standard 101 Life	K 000		

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K 000	Continued From page 2 Safety Code and Building 04 was built to the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code the two buildings were inspected separately. The facility is fully protected with an automatic sprinkler system and also has a fire alarm system which includes corridor smoke detection throughout and in all common areas. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 54 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 132 SS=D	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by:	K 132		8/3/22

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K 132	Continued From page 3 Based on observations and staff interview, it was revealed that the facility failed to maintain fire-rated occupancy separations per NFPA 101 (2012 edition), The Life Safety Code, sections 8.3.5, 8.3.5.1, and 19.1.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/29/2022, at 10:38 AM, it was revealed by observation that the north door of the double cross corridor doors in the 2 hour fire barrier leading to the Maple housing unit did not latch into the catch that is located in the header of the door frame. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 132	Latch adjusted and currently catches, maintenance will monitor this weekly for the first month, bi-weekly for the next month, once a month, then annually per Fire Door regulations. Door will also be inspected on Fire Drills.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the battery-operated emergency lights per the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code, sections 7.9.2.1, 7.9.3.1.1, and 19.2.9.1. These deficient findings could have a patterned impact on the residents within the facility.	K 291	1. Lights in Activities and Chapel will be tested monthly for 30 seconds 2. Lights in Activities and chapel will be testes annually for 90 minutes Both of these will be documented in the Life Safety Code log book, maintenance will monitor.	8/3/22

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K 291	Continued From page 4 Findings include: 1. On 06/29/2022, at 10:46 AM, it was revealed by observation that there are battery-operated emergency lights that are located within the Chapel and in the Activities rooms. It was also revealed during the review of all available battery operated emergency light test/inspection documentation and interview with the Maintenance Supervisor, that these battery operated emergency lights had not be tested monthly for 30 seconds. 2. On 06/29/2022, at 10:46 AM, it was revealed by observation that there are battery-operated emergency lights that are located within the Chapel and in the Activities rooms. It was also revealed during the review of all available battery operated emergency light test/inspection documentation and interview with the Maintenance Supervisor, that these battery operated emergency lights had not be tested annual for 90 minutes. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 291		
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.	K 346		8/3/22

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K 346	Continued From page 5 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, and staff interview, the facility has failed to provide a complete an acceptable written policy for when the Fire Alarm system has to be placed out-of-service per NFPA 101 (2012 edition), The Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/29/2022, at 10:22 AM, it was revealed during of all available records and an interview with a Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy. The current fire alarm system out of service policy did not have the name and contact information for the assigned State Fire Marshal for the facility. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 346	Fire Alarm System OOS Policy has been updated to include State Fire Marshall information. This document will be in the Life Safety Code log book, maintenance will monitor.	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the	K 354		8/3/22

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K 354	Continued From page 6 sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, and staff interview, the facility has failed to provide a complete an acceptable written policy for when the Fire sprinkler system has to be placed out-of-service per NFPA 101 (2012 edition), Life Safety Code, section 9.7.6, and NFPA 25 (2011 Edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/29/2022, at 10:22 AM, it was revealed during of all available records and an interview with a Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy. The current fire alarm system out of service policy did not have the name and contact information for the assigned State Fire Marshal for the facility. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 354	Sprinkler System OOS Policy has been updated to include State Fire Marshall Information. this document will be in the Life Safety Code log book, maintenance will monitor.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101	K 712		8/3/22

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K 712	Continued From page 7 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2, 19.7.1.6, and 4.7.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/29/2022, at 9:58 AM, it was revealed during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility failed to vary the times of the fire drills by conducting 4 of the 4 evening shift fire drills in the 2 PM hour 2. On 06/29/2022, at 9:58 AM, it was revealed during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that on 2 of 4 overnight fire drills that the facility did not have the overnight staff that participated in the drill sign the fire drill reports.	K 712	Fire Drill will be conducted at more random times, but will not be within the 30 minute shift change window. We will document all staff that participate during overnight drills. Administrator will audit monthly that fire drills are random and documentation is completed.	

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K 712	Continued From page 8 3. On 06/29/2022, at 9:58 AM, it was revealed during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that on 2 of 4 overnight fire drills that the facility did not record the times of when the fire drill was conducted on the fire drill reports. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/29/2022, at 10:17 AM, it was revealed	K 901	Facility was found to have failed to provide a complete facility Risk Assessment per NFPA 99. Maintenance supervisor will maintain a NFPA 99-2012 Utility Risk Assessment outlining room names and numbers throughout the facility; along with room category, space within room, and the proper risk assessment category related to “Med Gas”, “Electric”, and “HVAC” for each room.	8/3/22

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K 901	Continued From page 9 during a review of available documentation and an interview with the Maintenance Supervisor, that the utility risk assessment document provided at the time of the survey did not contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	The NFPA 99-2012 Utility Risk Assessment will also include an updated list of facility's electrical and gas equipment related to resident care with its risk number. The risk numbers range from 1-4 indicating whether the equipment failure may cause death or serious injury, minor injury, discomfort, or no impact. Maintenance supervisor will update any new equipment received throughout the year, otherwise this will be inspected annually. Assessment will be kept in the Life Safety Code log book. Administrator will audit that assessment is updated and in the book once every three months for one year.	

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	245399	A. BUILDING **04 - MECHANICAL ROOMS** B. WING _____	**06/29/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted on 06/29/2022, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Little Falls Care Center Building 04 - West building addition was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/22/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **04 - MECHANICAL ROOMS** B. WING _____	**06/29/2022**

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as two buildings: Building 04 - The West building is a 1 story building without a basement and was determined to be Type II(111) construction. Since Building 03 was built under the 2000 edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code and Building 04 was built to the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code the two buildings were inspected separately.	K 000		

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K 000	Continued From page 2 The facility is fully protected with an automatic sprinkler system installed and also has a fire alarm system which includes corridor smoke detection throughout and in all common areas that is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 54 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than four hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, and staff interview, the facility has failed to provide a complete an acceptable written policy for when the Fire Alarm system has to be placed out-of-service per NFPA 101 (2012 edition), The Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 346	Fire Alarm OOS Policy has been updated to include State Fire Marshall information. This document will be in the life Safety code log book, maintenance will monitor.	8/3/22

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K 346	Continued From page 3 On 06/29/2022, at 10:22 AM, it was revealed during of all available records and an interview with a Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy. The current fire alarm system out of service policy did not have the name and contact information for the assigned State Fire Marshal for the facility. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 346		
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, and staff interview, the facility has failed to provide a complete an acceptable written policy for when the Fire sprinkler system has to be placed out-of-service per NFPA 101 (2012 edition), Life Safety Code, section 9.7.6, and	K 354	Sprinkler System OOS Policy has been updated to include State Fire Marshall information. This document will be in the Life Safety Code log book, maintenance will monitor.	8/3/22

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K 354	Continued From page 4 NFPA 25 (2011 Edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/29/2022, at 10:22 AM, it was revealed during of all available records and an interview with a Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy. The current fire alarm system out of service policy did not have the name and contact information for the assigned State Fire Marshal for the facility. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 354		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by:	K 712		8/3/22

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K 712	Continued From page 5 Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2, 19.7.1.6, and 4.7.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/29/2022, at 9:58 AM, during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility failed to vary the times of the fire drills by conducting 4 of the 4 evening shift fire drills in the 2 PM hour 2. On 06/29/2022, at 9:58 AM, during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that on 2 of 4 overnight fire drills that the facility did not have the overnight staff that participated in the drill sign the fire drill reports. 3. On 06/29/2022, at 9:58 AM, during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that on 2 of 4 overnight fire drills that the facility did not record the times of when the fire drill was conducted on the fire drill reports. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 712	Fire Drill will be conducted at more random times but will not be within the 30 minute shift change. This is ongoing. We will document all staff that participate on overnight drills. This is ongoing. On overnight drills we will include times of testing and the system will be tested the following day. This is ongoing. Administrator will audit fire drills are random and documentation is completed.	
K 901 SS=C	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category	K 901		8/3/22

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K 901	Continued From page 6 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/29/2022, at 10:17 AM, it was revealed during a review of available documentation and an interview with the Maintenance Supervisor, that the utility risk assessment document provided at the time of the survey did not contain a complete list of the electrical and gaseous patients/residents care equipment and the associated risk categories for the patients/residents as outlined in 2012 edition of NFPA 99, The Health Care Facilities Code chapters 10 and 11. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	Facility was found to have failed to provide a complete facility Risk Assessment per NFPA 99. Maintenance supervisor will maintain a NFPA 99-2012 Utility Risk Assessment outlining room names and numbers throughout the facility; along with room category, space within room, and the proper risk assessment category related to “Med Gas”, “Electric”, and “HVAC” for each room. The NFPA 99-2012 Utility Risk Assessment will also include an updated list of facility’s electrical and gas equipment related to resident care with its risk number. The risk numbers range from 1-4 indicating whether the equipment failure may cause death or serious injury, minor injury, discomfort, or no impact. Maintenance supervisor will update any new equipment received throughout the year, otherwise this will be inspected annually. Assessment will be kept in the Life Safety Code log book. Administrator will audit that assessment is updated and in the book once every three months for one year.	