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	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Falls Care Center	1200 First Avenue Northeast Little Falls, MN 56345

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to ensure resident representative and physician were notified of falls with and without injuries for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's significant change Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included dementia, anxiety disorder, and had severely impaired cognition. R1 was noted to have two or more falls with no injury and one fall with injury. Review of R1's Fall Investigations for falls on 8/8/23, 8/10/23, 8/14/23, 8/20/23, 8/24/23, 9/10/23, 9/23/23, 9/25/24 and 9/27/23 all lacked evidence of resident representative or physician being notified. R1's Progress Notes revealed: -On 9/19/23, R1 was found on the floor next to his bed. Multiple bruising noted from multiple falls in the past. Progress note lacked evidence of resident representative or physician being notified of fall. -On 9/28/23, R1 had unwitnessed fall no injuries noted however progress note lacked evidence resident representative or physician was notified of fall. -On 10/6/23 resident was attempted to transfer self to bed from wheelchair and sat on the floor and no injuries were noted. Progress note lacked evidence of resident representative or physician was notified of fall. -On 10/13/23, R1 was found on floor mat he stated he crawled out of bed and no new injuries were noted. Progress note lacked evidence of resident representative or physician was notified of fall. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/24 at 4:34 p.m. registered nurse (RN)-A stated nursing staff who completed the incident report would be expected to notify resident's representative and physician following each fall whether there was an injury or not and the notification would be documented in the incident report. RN-A confirmed family was not notified for the following falls R1 had: 8/8/23, 8/10/23, 8/14/23, 8/20/23, 8/24/23, 9/10/23, 9/19/23, 9/28/23, 10/6/23 and 10/13/23. RN-A confirmed R1's physician was not notified for the following falls R1 had: 8/10/23, 8/20/23, 9/10/23, 9/19/23, 9/23/23, 9/25/23, 9/27/23, 9/28/23, 10/6/23 and 10/13/23. On 1/24/24 at 5:47 p.m., director of nursing (DON) indicated licensed nursing staff who completed the incident report for the fall would be expected to notify the resident's representative and the physician immediately following a fall whether there was an injury or not. DON stated notifications should be documented in the incident report on who was notified and the time. In addition, DON stated notifications to both resident representative and physician would be important to ensure they were aware as well as any input or insight on different interventions that could be attempted. Review of facility policy titled Accident/Incident revised 1/8/18, revealed when a resident suffered an injury due to accident/incident family or the responsible party will be notified immediately and if there was no injury, they would be notified within a reasonable time frame. Family or responsible party was to be advised of falls and all skin tears/bruises or other skin concerns. Further policy direct staff of notifying the physician immediately whenever an injury occurs, or medical treatment was required and for all other events physician to be notified within a reasonable time frame.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to comprehensively assess and implement continuous monitoring for signs and symptoms of urinary tract infection (UTI) and notify physician timely with change in condition and/or worsening symptoms for 1 of 3 residents (R1), who were reviewed for change in condition. Findings include: R1's significant change Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included dementia, anxiety disorder, and benign prostatic hyperplasia (BPH). R1 had severely impaired cognition and required intermittent catheterization and was noted to be occasionally incontinent of bladder and bowel. R1's care plan dated 1/23/24, identified R1 had bladder incontinent related to urinary retention and not being able to empty bladder requiring intermittent catheterization and occasional incontinence. R1's toileting schedule consisted of every 3-4 hours and as needed and directed staff to monitor urinary output and voiding pattern every shift, bladder scan if not voiding and intermittent catheterization by staff as needed. R1's care plan lacked evidence of being at risk for UTI's or staff direction on monitoring for UTI signs and symptoms. R1's Progress Notes indicated: -On 10/25/23 at 4:50 p.m., R1 had been experiencing hematuria with each void throughout the shift and had been noted to have increased confusion and tiredness. Temperature has remained afebrile (there was no temperature recorded to reference or establish a baseline). Case manager was updated and would update provider. Staff will continue to monitor. Progress note was revised on 10/26/23 to include: R1's family was contacted regarding R1's symptoms and family would like R1 to be checked and treated for a UTI. Nurse Practitioner would be onsite this afternoon, would update and request orders at that time. -On 10/25/23 at 9:40 p.m., staff reported R1 was voiding in the toilet. -On 10/25/23 at 9:40 p.m., R1 was noted to have increased confusion and was not verbal with staff per his baseline. R1 was also noted to have been experiencing hematuria (blood in urine). -On 10/26/23 at 3:28 p.m. (late entry dated 10/27/23), orders were written for straight catheterization and send for UA/UC (urine culture). -On 10/27/23 at 5:12 a.m., R1 had very foul-smelling urine that was also blood tinged. R1 had been noted to be more confused than normal for at least two days. R1 was also noted to have complaints for back pain and had cloudy urine. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's All Vitals report, revealed no temperature was recorded in R1's record until 10/27/23 at 1:17 p.m., when R1 was noted to have a temperature of 99.7 degrees Fahrenheit. Document also revealed there were no additional monitoring implemented following R1's change of condition that was noted on 10/25/23, for possible UTI. -On 10/27/23 at 9:55 a.m., R1 was noted to be more anxious than usual. R1's urine was noted to be foul smelling and dark in color. Vital signs were obtained and charted. Staff were unable to arouse R1 and he was noted to be snoring and sleeping soundly as well as incontinent brief being saturated. -On 10/27/23 at 1:19 p.m., no medications given unable to swallow. -On 10/27/23 at 1:42 p.m., a urine analysis (UA) was collected and sent to the hospital by taxicab. Urine was noted to be dark in color, thick residue, and high odor. -On 10/27/23 at 3:31 p.m., ambulance arrived and R1 was taken to the emergency department (ED). R1's Communication to Provider note dated 10/26/23, identified on 10/25/23, R1 was noted to have hematuria with each void, increased tiredness, increased confusion, and was afebrile (no temperature recorded for staff to reference). On 10/26/23, staff spoke with family, and they wanted to have a UA completed and appropriate treatment. Due to increased confusion, staff kept R1 in bed for safety. Further, nurse practitioner (NP)-A wrote an order for straight catheterization and obtain a UA/UC. R1's record lacked evidence of facility implementing their UTI policy which included obtaining vital signs every shift and reassessing for signs and symptoms of a UTI every shift once signs/symptoms have been identified which occurred on 10/25/23. In addition, R1's record lacked evidence R1's physician was notified of change in condition on 10/25/23, or when symptoms increased and/or worsened on the morning of 10/27/23. On 1/24/24 at 1:12 p.m., registered nurse (RN)-B stated if a resident were to have any signs or symptoms of a UTI, the resident would be placed on a 72-hour monitoring which would include symptom monitoring and encouraging fluids. If symptoms continue or worsen upon completion of the 72-hour monitoring, then a UA would be obtained. Further, RN-B stated dehydration, improper catheter care or peri cares, and history of urinary retention would put a resident at greater risk for UTI's and if left untreated or delay in medical treatment/interventions sepsis could occur. On 1/24/24 at 1:51 p.m., nursing assistant (NA)-A stated she recalled staff having concerns related to UTI signs and symptoms and the changes had occurred quickly. NA-A stated R1 had quit talking, remained in bed and a few days later was taken to the hospital where he passed away. On 1/24/24 at 3:07 p.m., NA-C stated she recalled R1 having UTI symptoms and had reported to multiple nurses multiple times but was unsure if nursing had addressed the concerns that had been reported. Further, NA-C stated she had seen an increase in R1's confusion and urine had an odor and was darker in color before R1 had went to the hospital where he was admitted and passed away. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/24 at 3:53 p.m., licensed practical nurse (LPN)-A stated if signs and symptoms of a UTI were reported she would put a progress note of resident's condition into their record and if there were three or more symptoms of UTI the provider would be notified to obtain a UA. LPN-A stated incontinence and dehydration would put a resident at greater risk for UTI's and if there were a delay in UTI treatment a resident could become septic which could happen within a day or two varying person to person. On 1/24/24 at 4:34 p.m., RN-A stated staff were expected to report any UTI signs or symptoms to the licensed nurse who would assess and write a progress note in the resident's record, the licensed nurse would then report the concerns to the case manager on the unit. Following notification, the facility policy directs staff to implement a 3-day UTI monitoring and document in the resident record the UTI protocol was started and notify infection control as well as dietary. Further, RN-A stated if the resident was exhibiting three or more signs and symptoms of a UTI the provider would be updated to obtain a UA and if two or less symptoms identified then the UTI protocol would be implemented. RN-A stated an UTI left untreated could lead to sepsis or death. In addition, RN-A confirmed R1's record lacked evidence of UTI protocol being implemented and no additional UTI monitoring. On 1/24/24 at 5:33 p.m., RN-C stated if signs and symptoms of UTI were reported, the licensed nurse would be expected to report the concerns to the case manager, and they would update the providers. Following notification to the case manager, nursing would implement monitoring for UTI's. Further, RN-C stated staff had reported R1 had blood in his urine and appeared off, so RN-C went to assess R1's condition at that time. RN-C stated he noted R1 to have increased confusion, not eating or drinking, appeared more tired and lethargic at moments. RN-C stated he notified the case manager at that time on R1's change in condition. In addition, RN-C stated he did not initiate an additional UTI monitoring per facility protocol. On 1/24/24 at 5:47 p.m. director of nursing (DON) stated staff were expected to initiate UTI facility protocol upon identification of signs and symptoms of UTI's which included increasing fluid intake and extra monitoring for three days and if interventions showed no improvement in symptoms staff would notify the provider. DON was unaware where staff were expected to document their additional UTI monitoring, but assume it would be under a nursing order in the electronic record. Further, DON stated if a resident was exhibiting three or more symptoms, then a UA/UC would be collected. DON stated dehydration, dementia, incontinence, and urinary retention would increase a resident's risk for UTI's. DON confirmed the facility UTI protocol with additional UTI monitoring was not implemented following R1's change in condition when UTI signs and symptoms were first noted. On 1/25/24 at 11:38 a.m. DON stated UTI monitoring would be expected to begin at the time the symptoms were first identified, and the monitoring would include signs and symptoms the resident was experiencing as well as vital signs and documenting in the resident record. Further, DON confirmed the provider was not notified of R1's condition until 1:10 p.m. on 10/27/23, even though symptoms were noted to worsen in the early morning of 10/27/23. In addition, DON stated during morning meeting with the team daily, hospitalization s are discussed, but could not recall if R1's hospitalization was discussed and if any concerns were identified or any changes were made. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/25/24 at 2:04 p.m., NP-A stated obtaining a UA within 24-hours after she wrote the order on 10/26/23 and staff obtaining the UA on 10/27/23 would be appropriate. NP-A stated she wrote the order for the UA due to family requesting treatment. Further, NP-A stated monitoring UTI's would be tough due to R1's diagnosis of dementia and due to R1's goals of care, which were comfort care, staff would not have went ahead and treated the UTI symptoms and R1 was a pretty sick guy. Review of facility policy titled Urinary Tract Infection Three (3) Day Prevention revised 6/4/18, indicated the purpose of the policy was to provide guidance to staff to enact a three-day prevention protocol for individuals receiving services with signs or symptoms of a UTI. The McGee's Criteria will be used as evidence-based criteria when the individual receiving services was exhibiting signs and symptoms of a UTI to determine if the criteria meet a diagnosis of a UTI. A thorough assessment was necessary and encouraged and the following protocol does not supersede clinical nursing judgement or physician's orders: signs and symptoms of UTI without a urinary catheter include acute dysuria or acute pain and fever or leukocytosis and at least one of the following: acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increased incontinence, new or marked increased urgency and new or marked increased frequency. Further, if the individual had two or less symptoms without a catheter the following would implement prior to calling physician to obtain an order for a UA/UC: increase and encourage fluids for 72 hours, record fluid intake, assess vital signs on the a.m. and p.m. shift for three days and as needed and document the results in the record, reassess for signs and symptoms of UTI each shift (morning, day, and night) and document findings in the individual's record, notify dietary department to give cranberry juice at all meals for 3 days or get a physician order for cranberry tabs, document when the UTI protocol was initiated and when signs and symptoms presented in the individual's record. Further policy directed staff to notify physician if symptoms worsen or if individual receiving services condition declines.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to comprehensively re-assess and revise resident's care plan for 1 of 3 residents (R1) reviewed, who was cognitively impaired and had multiple falls resulting in minor injuries. Findings include: R1's significant change Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included dementia, anxiety disorder, and had severely impaired cognition. R1 was noted to have two or more falls with no injuries and one fall with injury. R1's care plan dated 1/23/24, indicated R1 was identified to have periods of restlessness and would crawl out of bed onto fall mat due to delusions and staff were directed to distract resident and keep resident in the commons area when up in wheelchair. R1 was identified to have decreased ability to communicate and rarely or never understood others. Further, R1 was identified to be at risk for falls or injury due to cognitive deficits and directed staff to assist with proper footwear, encourage call light use for assistance, keep call light within reach, low bed with fall mats, and resident may lower self to fall mats. Review of R1's Fall Investigations included: -On 8/8/23, R1 had an unwitnessed fall with no injuries. Interdisciplinary team (IDT) discussed and determined R1 had a history of dementia and showed signs of confusion. R1 was found lying on the floor and he did not use call light at time of fall. IDT determined intervention was R1 to have bed in lowest position and use fall mats to prevent injury. -On 8/10/23, R1 had an unwitnessed fall with no injuries. IDT discussed and determined R1 had diagnosis of dementia and was unable to describe wants or needs. R1 had diagnosis of benign prostatic hyperplasia (BPH) which made him restless when needing to void. R1 was on a toileting program. R1 was found on the floor in front of his recliner with gripper socks on. IDT determined intervention to be having R1 sleep in his bed at night with bed low and floor mats down. However, R1's care plan lacked evidence intervention was implemented. -On 8/14/23, R1 had an unwitnessed fall with no injuries. Discussed in IDT, R1 had diagnosis of dementia and he was unable to describe wants and needs. R1 had diagnoses of BPH which makes him restless when needing to void. Staff assists with toileting program, and he requires to be bladder scanned and straight catheterized when unable to urinate. Resident was found on fall mat next to bed with no injury staff will monitor hourly during active hours. R1's record lacked evidence of defining when R1's active hours were for staff and care plan lacked evidence intervention was implemented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 8/20/23, R1 had a witnessed fall and had reopened a previous skin tear on left elbow. IDT discussed R1 was found after attempting to self-transfer out of wheelchair. R1 was unable to tell staff wants and needs and was on a toileting program. R1 was noted to become weak when standing and fell frequently. R1 was confused and did not understand the call light system. Intervention determined to be staff would lay R1 in bed when he returns from supper meal unless he was restless and then he would sit in the pod (commons area) for supervision. However, R1's care plan lacked evidence intervention was implemented. -On 8/24/23, R1 had unwitnessed fall with no injuries. IDT discussed R1 had a history of multiple falls and had diagnoses which included pain syndrome, BPH, anxiety disorder, and moderate dementia with agitation. R1 was unable to urinate frequently and required catheterization. R1 had been more active and was working with therapy on strength training and was attempting to self-transfer more frequently. Intervention was determined to have staff complete hourly rounds on R1 while in recliner and help him into wheelchair if fidgeting in recliner. However, R1's care plan lacked evidence intervention was implemented. -On 9/10/23, R1 had unwitnessed fall with no injuries. IDT reviewed and determined R1 had a history of frequent falls and R1 would place himself on his floor mats frequently without injury. R1 was found sitting on the side of his bed on the floor mat. IDT determined intervention to have R1 care planned to lower self to floor mat as desired. -On 9/23/23, R1 had unwitnessed fall and was observed to sustain skin tears to left elbow, right lower forearm, and right elbow. IDT discussed and determined R1 had a history of multiple falls and had thin skin. R1 had been wearing tubi-grips on his arms to help protect from injuries. R1 had a history of dementia and was unable to tell staff what his needs were. Staff found resident on floor next to bed on fall mat. IDT determined intervention to be R1 was being care planned to be on his fall mat by bed. -On 9/25/24, R1 had unwitnessed fall with bruising noted to scalp and face and an existing skin tear to right elbow was bleeding. IDT reviewed and determined R1 was found sitting on floor in front of his wheelchair. R1 had diagnosis of dementia with agitation. R1 becomes active in the evening hours. R1 would be in the commons area when he was up and roaming to assist with redirection. R1 had shown increased agitation and anxiety which IDT determined intervention to be to discuss with R1's physician as R1's anxiety medications were being adjusted. However, R1's record lacked evidence physician discussion was completed and/or what the results or recommendations made. -On 9/27/23, R1 had unwitnessed fall with no injuries. IDT discussed and determined R1 was care planned for fall mat without injury. R1's Progress Notes revealed: -On 9/19/23, R1 was found on the floor next to his bed. Multiple bruising noted from multiple falls in the past. Progress note lacked evidence of resident representative or physician being notified of fall. -On 9/28/23, R1 had unwitnessed fall no injuries noted however progress note lacked evidence resident representative or physician was notified of fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 10/6/23 resident was attempted to transfer self to bed from wheelchair and sat on the floor and no injuries were noted. Progress note lacked evidence of resident representative or physician was notified of fall. -On 10/13/23, R1 was found on floor mat he stated he crawled out of bed and no new injuries were noted. Progress note lacked evidence of resident representative or physician was notified of fall. R1's record lacked evidence of R1's falls that occurred on 9/19/23, 9/28/23, 10/6/23 and 10/13/23 had incident reports completed, root cause analysis completed, IDT review, or revision of care plan with new interventions to prevent reoccurrence. On 1/24/24 at 1:12 p.m., registered nurse (RN)-B stated each resident's care plan would identify if the resident were at risk for falls as well as staff direction on interventions to prevent falls. Further, RN-B stated R1 was very at risk for falls and would often fall from his bed and interventions included low bed with floor mat and a repositioning pillow on the outside of the bed, other than that RN-B was not aware of any additional fall interventions. On 1/24/24 at 1:51 p.m. nursing assistant (NA)-A stated resident who are determined to be at risk for falls and if they had any fall interventions in place they would be verbally communicated between shifts as well as in each resident's care plan for staff to review. NA-A stated R1 was at risk for falls and would often be found in the middle of his bedroom floor, and interventions included low bed with floor mats. Further, NA-A stated R1 had poor cognition and was not able to follow direction or use the call light system appropriately, and NA-A was not aware of any safety or hourly checks. On 1/24/24 at 2:21 p.m. NA-B stated fall interventions were available to staff either on the resident's care plan or on the group sheets and staff were expected to check for changes to both every shift. NA-B stated she recalled R1 being at risk for falls and interventions included low bed and fall mat but was not aware of any other interventions for falls. On 1/24/24 at 4:34 p.m. RN-A indicated licensed nursing staff were expected to complete an incident report following a fall and once completed the nurse should enter a progress note into the resident's record which would be reviewed by the case manager of the unit and brought up in the IDT morning meetings the following day. The IDT would then review the fall and the root cause and determine an intervention to implement to attempt to prevent reoccurrence and future falls. The IDT would then update the care plan with the determined intervention and the group sheets would be updated as well with the changes. RN-A stated R1 had multiple falls during his stay at the facility. RN-A stated while R1 was a resident at the facility, he had a different case manager and RN-A confirmed some of the interventions mentioned in R1's incident reports lacked evidence of being implemented as they were not shown on his care plan. RN-B was unsure why the interventions were not on the care plan or why incident reports had not been completed following some of his falls and they were not reviewed by IDT. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/24 at 5:47 p.m., director of nursing (DON) indicated the licensed nurse who responded to the fall would be expected to complete an incident report and attempt to determine an immediate intervention. The IDT then reviews the intervention and determines if the intervention was appropriate after discussing the root cause of the fall. The resident's care plan would then be expected to be revised with the new intervention and the group sheets would be updated to reflect the care plan which would be completed by the unit case manager. Further, DON stated R1 had a lot of restlessness and would crawl out of bed and interventions included a low bed with floor mats and he was care planned for placing self on floor as a behavior however, DON stated staff would have to witness the incident to determine if he placed self on the floor versus a fall and if the incident was unwitnessed then it would be suspected as a fall. Review of facility policy titled Accident/Incident revised 1/8/18, directed staff to complete an incident report for a fall that was witnessed or un-witnessed and falls included falling to a lower surface unless resident intentionally puts self on floor, or it was the result of an overwhelming external force. The initial accident/incident investigation would include: an incident report in the electronic medical record, complete a fall scene investigation for all fall incidents, root cause for the incident to be determined at the time of the incident and entered on the incident report, and immediate interventions developed to prevent the reoccurrence from happening again. Nursing documentation to include if new permanent interventions were initiated the residents care plan and aide assigned sheet will be updated and the nursing notes will reflect follow-up every shift for 24 hours to include resident condition, interventions that were initiated and the effectiveness of those initiated interventions. Further, interdisciplinary team (IDT) assessment follow-up as soon as possible to review the incident report for further assessment and make any further recommendations. Review of facility policy titled Fall Prevention and Management revised 3/7/22, indicated an immediate intervention will be put into place based on the potential root cause of the fall to prevent further falls. Nursing staff will document the fall by completing an incident report. The IDT will evaluate the fall by reviewing the fall incident report to determine a root cause analysis of the fall and further interventions may be put into place to help prevent further falls. Any further interventions developed will be documented. All interventions that are identified through the assessment/review process will be documented in the resident's care plan.

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	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Falls Care Center	1200 First Avenue Northeast Little Falls, MN 56345

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to identify target behaviors, revise care plans to include non-pharmacological interventions, and monitor effectiveness for 3 of 3 residents (R1, R2, R3) reviewed who were prescribed schedule psychotropic medications. Findings include: R1's significant change Minimal Data Set (MDS) dated [DATE], indicated R1 had a diagnosis of depression and did not exhibit any behaviors. R1's medication administration record (MAR) dated 10/1/23 through 10/31/23, revealed R1 had scheduled sertraline (Zoloft) 100 mg once daily with a start date of 8/7/23. R1's orders lacked evidence of behavior monitoring for any target behaviors. R1's Psychoactive Medication Informed Consent Form dated 8/7/23, identified R1 was prescribed Zoloft, an antidepressant, however document lacked evidence reason for use, target behaviors, and non-pharmacological interventions. R1's care plan lacked evidence of R1 requiring the use of an antidepressant, target behaviors staff would be expected to monitor as well as person-centered non-pharmacological interventions to use to alleviate any identified target behaviors. R2's quarterly MDS dated [DATE], indicated R1 had a diagnosis of depression and reported minor symptoms of depression. R2 was also noted to exhibit verbal behavioral symptoms. R2's physician orders dated 1/23/24, indicated R1 was prescribed Cymbalta 60 milligrams (mg) twice daily. R2's physician orders lacked evidence of behavior monitoring for any target behaviors. R2's Psychoactive Medication Informed Consent Form dated 11/24/18, revealed sadness and feeling down in the dumps as target behaviors or reason for the use of the psychotropic medication Cymbalta. Non-pharmacological interventions to try included activities and visiting with family. R2's care plan dated 1/23/24, indicated R1 received antidepressant medication related to diagnosis of depression and interventions included work with a psychiatric team, make referrals for mood as needed, and meet with resident and/or family as needed to address concerns. R2's care plan lacked evidence of target behaviors staff would be expected to monitor as well as person-centered non-pharmacological interventions to use to alleviate any identified target behaviors. R3's quarterly MDS dated [DATE], indicated R3 had diagnoses of Parkinson's Disease and depression and denied feelings of depression at that time. R3 was also noted to exhibit no behaviors. (continued on next page)

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	01/25/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's electronic medication administration record (eMAR) dated 1/1/24 through 1/23/24, indicated R1 was prescribed Venlafaxine 225 mg once daily. R3's eMAR lacked evidence of behavior monitoring for any target behaviors. R3's Psychoactive Medication Informed Consent Form dated 11/29/22, lacked evidence of identifying any target behaviors and reason for use of psychotropic medication as well as non-pharmacological interventions to alleviate any behaviors. R3's care plan dated 1/23/24, indicated R2 was receiving antidepressant medication related to diagnosis of depression and interventions included administering medication as ordered, observe for side effects, make referrals for mood as needed and meet with resident and/or family to address concerns as needed. R3's care plan lacked evidence of target behaviors staff would be expected to monitor as well as person-centered non-pharmacological interventions to use to alleviate any identified target behaviors. On 1/24/24 at 5:47 p.m. director of nursing (DON) indicated residents who are prescribed a psychotropic medication would need a consent formed completed (Psychoactive Medication Informed Consent Form) which would have target behaviors staff and resident would identify for the use of the medication as well as alternative interventions aside from the medication. Further, staff would be expected to update the resident's care plan with the identified target behaviors and the person-centered interventions and implement monitoring for those target behaviors into the resident's record which would be completed by social services. In addition, DON confirmed R1's, R2's and R3's medical record lacked evidence of target behaviors identified in the care plan and lacked monitoring of behaviors to determine unnecessary psychotropic medication use. Review of facility policy titled Psychotropic Mediations dated 9/11/13, revealed primary care physician will identify Target Behavior symptoms for the reason the medication was being utilized. Nursing staff would be expected to monitor psychotropic drug use daily, noting any adverse effects, and monitor for the presence of target behaviors daily and charting by exception. Social Services would be expected to develop a behavioral care plan.