

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Little Falls Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40938</b></p> <p>Based on interview and document review, the facility failed to ensure resident's family and/or representative were updated timely for a change in condition related to resident death for 2 of 2 residents (R203 and R205) reviewed for notification of change.</p> <p>Findings include:</p> <p>Review of R203 electronic health record (EHR) identified a progress note dated [DATE], indicated at 9:45 p. m. R203 was found unresponsive with no vital signs, call was placed to hospice agency at 9:51 p.m. However, R203's EHR failed to indicate family/resident representative was updated regarding R203 passing away.</p> <p>When interviewed on [DATE] at 1:28 p.m., family member (FM)-B stated the facility did not contact the family when he was declining the day he died , family was informed two hours after he had passed away. FM-B stated family was told someone had sat with R203 while he was declining but there was no phone call made.</p> <p>When interviewed on [DATE], at 2:46 p.m. assistant director of nursing (ADON) stated typically hospice would update the family after a visit. ADON would attempt to locate notification to family regarding R203 passing away however, no documentation regarding family notification was provided.</p> <p>When interviewed on [DATE], at 1:06 p.m. FM-C stated facility called on [DATE] at about 2:30 p.m. to report R205 had a fall, received cardio pulmonary resuscitation (CPR) about 1:00 p.m., R205 passed away about 1:40 p.m. FM-C further stated family had not been informed R205 had facial injuries from the fall until the funeral had called them about bruising. FM-C identified in [DATE] R205 was sent to the hospital, family was not informed until the hospital called 13 hours later that R205 was being sent to a different hospital.</p> <p>Progress note dated [DATE], indicated R205 reported weakness earlier throughout the day was not feeling well, had shortness of breath, was unable to bear weight and respirations were increased. Progress note failed to identify notification to family of change in condition.</p> <p>Progress note dated [DATE], indicated R205 was out of the facility, was transported [DATE], to the hospital via ambulance on the PM shift. R205's EHR failed to identify family was notified R205 had been transported to the hospital.</p> <p>(continued on next page)</p>		

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Little Falls Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R205's EHR identified progress note dated [DATE], R205 was found face down on the floor in a pool of blood with electric recliner tilted up in the air. CPR was started and 911 was called. emergency medical services (EMS) arrived about 1:20 p.m. EMS called the time of death at about 1:50 p.m., provider and coroner were called at 4:45 p.m., funeral home contacted at 3:40 p.m., family updated, however progress note failed to identify when the family was notified.</p> <p>During interview on [DATE], at 1:35 p.m. registered nurse (RN)-A sated R205 did not have a change in condition until found on the floor. R205 had been found face first on the floor with cut on nose bleeding from the cut. Family was updated, could not recall what time but was after CPR was started. RN-A did not recall family being notified of facial injuries due to the fall.</p> <p>During interview on [DATE], at 2:53 p.m. ADON stated family was notified after CPR was stopped. ADON stated she would not have expected someone to notify family during the emergency, a staff member could have stepped away after EMS arrived and took over however this was not done. ADON was not aware of family was not notified of January hospitalization notification.</p> <p>Facility policy Notification of Significant Changes reviewed [DATE], indicated charge nurse would immediately inform the resident representative for significant change situations including any accident involving the resident which resulted in injury, a deterioration in health. decision to transfer to another provider or death of a resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Little Falls Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40938</p> <p>Based on interview and document review, the facility failed to ensure the long-term care (LTC) Ombudsman was notified of hospitalization s (i.e., facility-initiated discharges) for 5 of 6 residents (R11, R15, R24, R34, and R51) reviewed for hospitalization .</p> <p>Findings include:</p> <p>R11's significant change Minimum Data Set (MDS) dated [DATE], identified R11 as medically complex with intact cognition and diagnoses of hypertension, schizotypal disorder, pain in right leg, polymyalgia rheumatica, localized edema, morbid obesity due to excess calories, insomnia due to other mental disorder, depression, and urinary tract infection (last 30 days).</p> <p>R11's progress noted dated 3/7/24 indicated resident temperature was elevated and he was experiencing pain. Resident requested to be transported to the emergency room (ER) due to increased pain to right lower extremity (RLE).</p> <p>R11's progress noted dated 3/8/24 indicated resident admitted to the hospital with dehydration, urinary tract infection (UTI), pain, and frequent falls.</p> <p>R11 was admitted to CHI St Gabriel's Hospital 3/7/24-3/11/24. Prior to transfer R11 signed a Bed Hold Election and Hospital Transfer form.</p> <p>R11's progress noted dated 3/11/24 indicated resident returned from the hospital after being treated with intravenous (IV) antibiotics. However, R11's medical record lacked evidence the LTC Ombudsman had been notified of hospitalization .</p> <p>R15's annual Minimum Data Set (MDS) dated [DATE], identified R15 had intact cognition and required assistance with all activities of daily living (ADL)'s.</p> <p>R15's progress note, dated 3/1/24, identified R15 was experiencing increased shortness of breath and low oxygen saturations.</p> <p>R15's progress note, dated 3/1/24, identified R15 was readmitted to the nursing home with a diagnosis of Influenza A. However, R15's medical record lacked evidence the LTC Ombudsman had been notified of transfer.</p> <p>R24's significant change Minimum Data Set (MDS) dated [DATE], identified R24 was cognitively intact, and required assistance/supervision with activities of daily living (ADL)'s).</p> <p>R24's progress noted dated 2/12/24, identified R24's blood pressure had gone extremely low while at an appointment outside of facility and was sent to the emergency department (ED) for evaluation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Little Falls Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>R24's progress note, dated 2/15/24, identified R24 was readmitted to the nursing home after being hospitalized for UTI and hypotension. However, R24's medical record lacked evidence the LTC Ombudsman had been notified of hospitalization .</p> <p>R34's admission MDS dated [DATE], identified R34 was cognitively intact, and required assistance/supervision with ADL's</p> <p>R34's progress note, dated 4/5/24, identified R34's stoma was edematous (swollen) and protruding and was sent to the ED for evaluation.</p> <p>R34's progress note, dated 4/5/24, identified R34 was readmitted to the nursing home after being evaluated. However, R15's medical record lacked evidence the LTC Ombudsman had been notified of transfer.</p> <p>R51s admission minimum data set (MDS) dated [DATE], indicated R51 was cognitively intact, and required moderate staff assist with activities of daily living (ADL)'s. Diagnoses included coronary artery disease, heart failure, respiratory failure, hypertension</p> <p>R51's progress noted, dated 2/04/2024, identified R51 complained of a worsening headache, with dizziness, developed confusion and difficulty finding words. R51 ws transferred to the hospital.</p> <p>However, R51's medical record lacked evidence the LTC Ombudsman had been notified of transfer.</p> <p>On 4/15/24 at 4:13 p.m., LTC Ombudsman sent an email to surveyor stating that she had not received any notices of transfers or discharges from the facility for over a year. Ombudsman stated she had spoken to the administrator and activity director about this in the past.</p> <p>During interview on 4/16/24 at 1:42 p.m., nurse consultant (NC) stated the facility could not locate records to indicate the LTC Ombudsman had been notified of transfers and/or discharges.</p> <p>The Transfer and Discharge from Facility policy was requested but was not received.</p> <p>47638</p> <p>48013</p>		