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	08/22/2025

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify physician and resident representative timely of a new injury for 1 of 3 residents (R1) reviewed.Findings include:R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included traumatic subdural hemorrhage, cerebral infarction, anxiety disorder, and had severely impaired cognition.R1's skin incident report dated 8/10/25, revealed registered nurse (RN)-D was called into R1's room to assess a skin tear to left front of lower shin. Staff had explained that they were getting R1 up and ready for the day and she pulled her pants down to change them. Upon lowering her pants, staff noticed that there was blood on the sheet and when she looked where it was coming from, staff observed a skin tear. RN-D completed wound care by cleaning and covering with bandage. R1 denied any pain in the area, but upon completing wound care R1 was seen wincing in pain. Both RN-D and staff assisted by applying Tubi grips to both lower extremities and proceeded to continue cares. Injuries observed at the time of the incident was a skin tear to left lower leg, RN-D cleansed wound with wound cleanser, skin flap was approximated with Q-Tip and covered with non-adherent pad, leg was then wrapped with rolled gauze and secured with tape, Tubi-grip placed over leg to hold dressing in place. Further incident report revealed R1's physician was notified on 8/12/25 at 2:05 p.m., and there was no evidence of resident representative being notified.R1's progress note dated 8/10/25 at 9:23 p.m., R1's left leg skin tear dressing was removed by a nursing assistant because R1's daughter wanted to look at the wound. R1's record lacked evidence of R1's representative being notified prior and notification to resident's physician. On 8/20/25 at 12:16 p.m., R1's resident representative (RR) stated she was at the facility on 8/09/25, and when she came to the facility on 8/10/25, RR stated she inquired to staff about a bruise on her arm and that was when the staff notified her of the skin tear on R1's leg. RR stated typically she would receive a phone call from the staff on incidents, but she was not notified of the skin tear until later in the day.On 8/20/25 at 3:52 p.m., RN-A stated staff were expected to notify provider and family as soon as staff were aware of any new skin impairments.On 8/20/25 at 9:25 a.m., licensed practical nurse (LPN)-A stated new injuries or skin impairments were expected to be reported to the charge nurse and they would complete an incident report and inform the unit case managers and director of nursing (DON), and the DON would notify the physician and family as soon as the DON was made aware.On 8/21/25 at 10:08 a.m., RN-B stated new skin impairments were expected to be reported to the physician and family immediately or within your shift depending on severity. The floor nurse would be expected to complete an incident report and part of the incident report would be notifications to appropriate parties such as physician, family and DON.On 8/21/25 at 3:15 p.m., RN-C stated for new skin impairments, the floor nurse was expected to complete a risk management (incident report), provide aid and treatment to the injury, notify DON and nurse on call. Further, RN-C stated the physician, and resident representative would be expected to be notified immediately as well. On 8/21/25 at 4:40 p.m., attempted interview with R1's provider was unsuccessful.On 8/22/25 at 8:56 a.m., DON stated staff were expected to complete an incident report upon discovering a new skin impairment, and part of the document required staff to notify the physician and resident representative. DON stated RN-D discovered the skin tear in the early morning of 8/10/25 and passed on in report to the next shift because RN-D was unable to complete all tasks due to having a busy night. DON stated RR was upset she was not notified.On 8/22/25 at 9:59 a.m., RN-D stated at approximately 5:30 a.m. on 8/10/25, RN-D was paged to go to R1's room and RN-D observed the skin tear. RN-D stated she assessed the wound and passed through report to the next shift of the update. RN-D stated she was not completed with her charting at 6:30 a.m. when her shift was over, so RN-D returned to the facility later that afternoon to complete the incident report. RN-D stated she was aware she did not notify R1's resident representative and I am sure [RR] was not happy, and RN-D confirmed she did not notify R1's physician because, it all happened so fast. Further, RN-D stated notifying the physician and resident representative was part of completing the incident report, and staff were expected to call nurse triage and leave a message for the resident's physician and notify the resident's representative.On 8/26/25 at 11:30 a.m., return call from RN-E, nurse at R1's physician's office, RN-E confirmed the provider was not notified of R1's skin tear until a note was received from the facility a couple days later about a wound dressing.A copy of the facility's notification policy was requested but facility failed to provide.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure care plan interventions for transfers were implemented for 1 of 3 residents (R1) reviewed.Findings include:R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included traumatic subdural hemorrhage, cerebral infarction, anxiety disorder, and R1 had severely impaired cognition.R1's care plan revised on 8/9/25, identified R1 had an activities of daily living (ADL) self- care deficit related to confusion due to recent stroke and staff were direct to ambulate R1 to meals as able with a single quad cane, gait belt, and contact guard assist, recommend another staff to follow with wheelchair and the nurse would document all attempts that fail. R1's care plan also directed staff to ambulate R1 to and from the bathroom with assist of one and a single quad cane, gait belt, and contact guard assist, recommend another staff to follow with wheelchair and nurse to document all attempts that fail.R1's Progress Note dated 8/20/25, revealed no change in condition noted this shift. R1 required extensive assist of one with the non-mechanical sit to stand lift and R1 did not exhibit any behaviors. R1's record lacked evidence of any failed attempts related to transfers or ambulation. On 8/20/25 at 12:16 p.m., anonymous reporter (AR) stated R1 received outpatient therapy and R1 was provided with orders for facility staff to assist R1 with ambulating to and from the bathroom with a cane, as well as to and from meals as tolerated. AR stated the facility were not following R1's care plan and had been transferring R1 using a non-mechanical stand lift. On 8/20/25 at 3:52 p.m., registered nurse (RN)-A stated R1 required assistance by staff for all activities of daily living (ADL), and R1's care plan at this time identified R1 required assistance by one staff member for stand and pivot transfers and utilizing a cane for ambulation. Further, RN-A stated at times R1 would be weaker and require more staff assistance with transfers and the use of a non-mechanical stand lift. On 8/21/25 at 9:25 a.m. licensed practical nurse (LPN)-A stated R1 required assistance with all ADLs and required a non-mechanical sit to stand lift for transfers and depending on the day was able to stand and pivot but was unable to ambulate. On 8/21/25 at 10:08 a.m., RN-B stated R1 was not resistive to cares and was usually easy to talk through tasks and allow staff to assist with tasks. RN-A stated R1 required a non-mechanical sit to stand lift for transfers assistance by one staff, and RN-A stated she had not witnessed R1 ambulate at the facility but R1 was able to ambulate in therapy. On 8/22/25 at 12:00 p.m., nursing assistant (NA) stated R1 recently received new therapy orders directing staff to assist with ambulating to and from the restroom with a cane and gait belt. NA-A stated R1 often chooses which staff she prefers to ambulate for and if R1 was not compliant staff would often use the non-mechanical sit to stand lift to transfer. On 8/21/25 at 12:15 p.m., NA-A was observed assisting R1 in her wheelchair to R1's room. NA-A asked R1 if she was able to walk to the bathroom and R1 stated yes, so NA-A placed a gait belt around R1's waist and R1 stated she wanted to use her walker instead of the cane. R1 placed hands on the walker and stood from her wheelchair and walked into the bathroom with NA-A holding onto the gait belt. R1 walked back out of the bathroom with the walker and appeared to be steady with NA-A holding the gait belt, R1 pivoted and sat back down in her wheelchair. On 8/21/25 at 1:46 p.m., NA-B was observed to assist R1 in her wheelchair back to her room. R1 appeared to be tearful and upset related to her family leaving her, but NA-B offered reassurance. NA-B exited R1's room and returned with the non-mechanical sit to stand lift. NA-B moved R1's wheelchair pedals off to the sit and positioned the lift in front of R1. R1 placed her feet on the platform, NA-B locks wheelchair brakes as well as the lift brakes and directs R1 to grab onto the bars and stand up. R1 follows all ques and stands up, and NA-B places the two paddles behind R1's bottom, unlocks lift brakes and brings R1 into the bathroom. NA-B then maneuvered R1 out of the bathroom in the lift and opens the lift legs over R1's wheelchair, locks the lift brakes and directs R1 to stand, paddles are removed and R1 sits down in her wheelchair. On 8/21/25 at 2:06 p.m., R1 was sitting in her wheelchair in her room and stated she was able to walk just fine to and from the bathroom with a cane, but R1 was unsure why the staff were using a lift instead. R1 stated I am afraid to ask they would tell me something I don't want to hear. On 8/21/25 at 2:25 p.m. NA-B stated all NA's have access to each resident's care plan which would identify what each resident's transfer status and ADL assistance was. If there were changes to a resident's care plan the changes were communicated through verbal report at change of shift. Further, NA-B stated R1 required a non-mechanical sit to stand lift always and R1 was able to ambulate with a walker and a gait belt. On 8/21/25 at 2:59 p.m., NA-C stated R1 required staff assistance with all ADLs and transferred with a non-mechanical sit to stand lift. NA-C stated R1 was not able to ambulate that she was aware of. On 8/21/25 at 3:15 p.m.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to monitor, review, and analyze underlying causes of resident's anxiety and agitation for 1 of 1 resident (R1) who was reviewed for behaviors.Findings include:R1's quarterly Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses which included traumatic subdural hemorrhage, cerebral infarction, anxiety disorder, and R1 had severely impaired cognition and R1 did not exhibit any behaviors.R1's medication administration record (MAR) and treatment administration record (TAR) for the month of August 2025, revealed R1 was prescribed Trazodone 100 mg at bedtime for insomnia. TAR lacked evidence of target behaviors being monitored.R1's Psychoactive Medication Informed Consent Form dated 3/19/25, revealed R1 was prescribed Trazodone, but the document lacked reason for use (target behaviors) of this psychoactive medication, non-pharmacological interventions, or benefits to be obtained in using this medication.R1's care plan as of 8/20/25, indicated R1 had impaired cognitive function and impaired thought processes related to disease process and recent stroke. R1 was also noted to have a communication problem related to expressive aphasia and receptive aphasia. R1 was at risk for falls related to confusion, gait/balance problems, psychoactive drug use, unaware of safety needs and directed staff to check for urinary tract infection with increased restlessness and confusion, and when restless at night offer a snack and something to drink. Further, R1's care plan identified R1 had difficulty with sleep and directed staff to administer any medications per provider order, monitor for side effects and effectiveness, offer a snack of pudding/toast for nighttime restlessness, discourage a pattern of daytime naps, and encourage R1 to follow a consistent routine retiring and arising. R1's Progress Notes revealed the following:-On 8/19/25, moved the trash bin she was running into and tried to move her to a more open area however continued to run into things.-On 8/19/25, minimal sleep this shift from 0100-0300. Restlessness and wandering remain evident throughout the pod, attempted to enter other resident's rooms as well as other rooms on the floor (shower room, clean utility room and dirt utility room).-On 8/18/25, resident has been wheeling self-backwards at an extensive rate of speed. Due to impairments of ability to see when wheeling backwards, resident then runs into items aggressively (walls, lifts, other residents, etc.) Resident was witnessed to have run into another resident his shift while this resident was sitting out on the pod. Resident had run into the back of the wheelchair and no injuries were sustained but when redirected, the behaviors did not change.-On 8/18/25, resident wandered into another resident's room who was sleeping, entered the room and began to attempt to rove their walker, thus resulting in this resident becoming entangled in the walker, nearly causing them to fall. Resident was redirected back to the center of the pod but wandering remains present as well as discussions toward other confused residents, stating you stay over there and stay away from me or else.-On 8/18/25, resident completely unconsolable this shift regardless of attempts from staff or other residents. Yelling out help, get him away from me. Resident crying uncontrollably to the extent that she was unable to catch her breathe. Behaviors only subside when resident was on a one to one with another staff member. There are no PRN (as needed medication) available to assist with increased anxiety and restlessness.-On 8/15/25, resident was wheeling herself backwards and yelling help repeatedly and trying to go into other people's rooms. Staff tried to offer a snack, which she did not want. Tried offering resident to watch a show on the tablet, which was not effective. When asking resident what her need was, she would say I don't need anything. No pharmacological interventions available currently.-On 8/11/25, R1 was yelling at staff to get out of here, you need to die and I'm going to kill you. R1 had been exhibiting behaviors since 2:00 p.m. Distraction, food, drink and toileting were not effective. There were no pharmacological intervention to give her. Daughter came in at about 6:30 p.m. took her outside and when daughter brought her back in the yelling started all over again. -On 8/9/25, resident was heard yelling at another resident on the pod. Staff tried to redirect resident away and continued to yell inappropriate words at another resident. Resident was then [NAME] down to other wing to completely change surroundings and resident continued to yell out obscenities and inappropriate comments to nurse and staff on that side. Non-pharmacological interventions attempted included one to one staff involvement, took for ride in wheelchair around inside of the building, offered snack and drink which were not effective.-On 7/24/25, resident was weeping and crying and stated, I might as well be dead. One to one distraction did not seem to be effective, and resident would continue to have weeping episodes.-On 7/19/25, resident was yelling out for help, thinks resident was trying to kill us thinking she had to clean something up. Distraction, toileting and