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	12/31/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - 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 follow the care plan to ensure safe transfers to eliminate/reduce the risk of an accident during a transfer for 1 of 3 residents (R1). This resulted in actual harm when R1 fell, sustained a significant head injury (brain bleed) that required hospitalization. The facility had implemented actions to prevent reoccurrence prior to the survey; therefore, the citation was issued at past non-compliance (PNC).Findings include:Findings include:R1's order summary report 9/2/25, indicated R1's diagnoses included primary hypertension, persistent atrial fibrillation, prediabetes, generalized weakness, chronic respiratory failure, abnormalities of gait and mobility.R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment and required substantial/maximal assistance for toileting, transfer, as well as mobility/ambulating.R1's activities of daily living (ADLs) care plan dated 1/1/25, indicated R1 required assistance of one with walker with ambulation as well as mobility and transfers. R1's ADLs care plan dated 1/1/25, directed staff to ensure R1 had footwear for ambulation and mobility. A historic intervention initiated 1/1/25 and cancelled on 12/23/25, informed R1 was substantial/maximal assistance- Helper does more than half the effort. Helper lifts or holds trunk or limbs. R1's progress note dated 12/17/25 at 3:00 p.m., indicated R1 had a fall in the bathroom hitting her head on the wall while she was stepping off the weight's scale. The note further indicated the provider and the family were notified, and neuro check initiated.R1's progress note dated 12/17/25 at 3:04 p.m., indicated R1 had a witness fall hitting her head against the wall while she was stepping off the scale in the bathroom without footwear. Staff did not assist R1 to step off the scale and gait belt was not used either during the transfer. The root cause analysis for the fall identified R1 became weak/lost balance while standing on scale for weight check with the corresponding intervention identified as staff were to ensure R1 had footwear with gait belt and one assist during mobility/transfer.R1‘s progress note dated 12/20/25 at 11:20 a.m., indicated R1 was confused and drowsy at breakfast time. Staff transferred R1 with two assists with non-mechanical lift to the toilet to get a urine sample due to an increased confusion and a decreased of level of conscience (LOC). Per the family request, R1 was transported to the hospital.R1's emergency department (ED) provider notes dated 12/20/25 identified R1 was transferred to the ED for an evaluation of a known head bleed. The note further indicated R1's family reported that R1 fell 3 days ago at the nursing home when she was having worsening confusion, altered level of consciousness and decreased appetite, and fatigue. R1's head computed tomography (CT) scan showed bleeding in her brain. R1 was found to have an intraparenchymal hemorrhage of the right temporal occipital junction with subdural blood products along the right tentorium. R1's computed tomography (CT) head scan without intravenous (IV) contrast note dated 12/20/25 at 2:18 p. m., identified R1 had intraparenchymal hemorrhage in the region of the right temporal occipital junction with subdural blood product extending along the right tentorial reflection.R1's magnetic resonance imaging (MRI) head scan without and with contrast note dated 12/21/25 at 11:31 a.m., indicated minor subdural hematoma along the right convexity and intra-axial hemorrhage grossly noted.During an interview on 12/30/25 at 12:30 p.m., a family member (FM)-A stated staff informed her R1 fell on the scale and hit her head against the wall in the bathroom on 12/17/25. FM-A stated the fall occurred when staff did not follow proper protocol during weight check for heart failure management, leaving R1 standing and unsupported. FM-A stated since the fall, R1 has been less interactive, with increased confusion and decreased oral intake. FM-A stated on 12/20/25, R1 was found to be very sleepy, confused, and not acting like herself. FM-A stated she requested R1 to be sent to the hospital for further evaluation.During an interview on 12/30/25 at 3:07 p.m., a registered nurse (RN)-A, a case manager stated she was informed on 12/17/25 that R1 hit back of her head against the wall in the bathroom during a transfer in which the care plan was not followed. RN-A stated it was unsafe to stand R1 alone on the scale unsupported. RN-A stated it was on 12/20/25 she noted R1 had increased confusion and not acting like herself. Per FM-A request, she sent R1 to the hospital. RN-A stated she did not provide an education to the staff that was involved in the fall accident right away and the staff continued to care for other residents until 12/20/25 when R1 was sent to the hospital.During interview on 12/31/25 10:30 a.m., a licensed practical nurse (LPN)-A stated when head was involved in the fall accident, staff should initiated neuro check, do the vital signs, monitoring the resident, and provided an update to the provider and the family. LPN-A stated depending on the resident condition, she will request imaging from the provider to rule out brain injury.During an interview on 12/31/25 at 10:41 a.m., NA-B stated she checked the care plan to be