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	04/20/2026

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 - 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** Based on interview and document review the facility failed to complete comprehensively assess level of supervision and failed to complete root cause analysis (RCA) following falls for 1 of 3 residents (R1) reviewed for falls.Findings include R1's psychiatric mental health evaluation summary note dated 2/25/26, indicated R1's diagnoses included major neurocognitive disorder due to vascular disease, with behavioral disturbance, severe, abnormalities of gait and mobility, repeated falls, cerebral vascular disease (CVA) with left hemiparesis, acute encephalopathy, and chronic pain.R1's comprehensive quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and required substantial/maximal assistance for toileting, transfers, lying to sitting on bed side, and put on/take off footwear.R1's activities of daily living (ADLs) care plan dated 2/19/25 revised on 3/1/26, indicated R1 required assistance of two with stand assist utilize full mechanical lift as needed for weakness or fatigue for transfers. R1's ADLs care plan dated 2/19/25 revised 8/28/25, directed staff to turn and reposition R1 in bed every 2-3 hours and as necessary. R1's ADLs care plan dated 8/22/25, directed staff to analyze time of day, places, circumstances, triggers, and what de-escalates behavior and document these findings. Additionally, R1's ADLs care plan dated 8/22/25 directed staff to assess and anticipate R1's toileting needs, comfort level, body positioning, pain etc. Despite these directives, the care plan did not include enhanced supervision or incorporate the psychiatric evaluation's recommendation for 24-hour supervision, completed on 2/25/26.R1's psychiatric mental health evaluation dated 2/25/26, recommended R1 required 24-hour supervision to ensure safety. The evaluation further indicated simple ADLs needed to be initiated by caregiver and continual supervision may be needed to correct R1's behaviors.R1's medical record review from February and March 2026 showed no adequate documented analysis of root causes, no evidence that the interdisciplinary team revised the care plan, and no documentation that R1's supervision needs were reassessed according to the psychiatric evaluation.R1's progress note dated 2/18/26 at 8:25 p.m., indicated R1 had an unwitnessed fall in the lounge area next to brick wall when her wheelchair (WC) had stuck in a curve of the wall. The note further indicated R1 slipped out of WC landing on pedals with her knees bent under her. Staff assisted R1 straighten legs out and then used a full mechanical lift to transfer R1 back into her WC. The root cause analysis was not identified but the corresponding interventions identified as staff were to ensure R1 had been toileted every two hours, change and reposition, bed in lower position, and call light within reach.R1's progress note dated 2/25/26 at 9:14 p.m., indicated R1 experienced an unwitnessed fall in the hallway. Staff reported R1 had been pushing herself around the pod in an attempt to leave the building and was found sitting on the pedals of her WC. No injuries were noted. The root cause analysis identified R1 had slipped out of her WC due to the right foot pedal being in the down position. R1 used only one foot pedal because she propelled herself with her other foot, which increased the likelihood of sliding forward when the unused pedal remained attached. The corresponding intervention was to remove the right foot pedal, label it, and store it in the closet for use only during medical appointments.R1's progress note dated 3/4/26 at 10:59 p.m., indicated R1 had unwitnessed fall in her room with no injuries. The note lacked (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 - Minimal harm or potential for actual harm Residents Affected - Few	evidence of the root cause analysis for the fall. The note lacked the root cause analysis for the fall.R1's progress note dated 3/16/26 at 6:40 a.m., indicated R1 had unwitnessed fall in her room where she was found laying partially on the floor and partially on the fall mat next to her bed. The note further indicated R1 was found on the floor by another resident. Upon assessment, R1 did not sustain any injuries but staff were unable to rule out head strike and staff used mechanical lift to transfer R1 from the floor back to bed. However, the progress note did not include evidence of a root cause analysis (RCA) for the fall.R1's progress note dated 3/17/26 at 00: 30 a.m., indicated R1 had unwitnessed fall on 3/16/26 at 8:30 p.m. Staff found R1 lying on her floor mat with her bedding wrapped around her lower extremities. No injuries were noted. The note lacked evidence of the root cause analysis for the fall. Staff documented they have requested the provider to reconcile R1's medications to promote improved sleep patterns; however, this intervention alone did not substitute for a comprehensive RCA to determine why the fall occurred or how to prevent recurrence.R1's progress note dated 3/18/26 at 00:17 a.m., indicated R1 experienced unwitnessed fall on 3/17/26 at 10:10 p.m. Staff found R1 lying next to her bed, partially on the fall mat and partially on the floor, positioned on her left side. Her brief on the bed, and she was incontinent of urine. R1 did not sustain any visible injuries and transferred back to bed using a full mechanical lift. The note lacked evidence of the RCA.R1's treatment administration record dated March 2026, indicated R1 had a fall on 3/29/26 at 1:00 p.m. with no injury. R1's record did not include a comprehensive root cause analysis. =R1 experienced seven unwitnessed falls between 2/25/26 and 3/17/26. During this period, R1's psychiatric mental health evaluation identified a need for continuous supervision, yet across these events, the facility's documentation showed inconsistent completion of root cause analyses and limited evidence of comprehensive evaluation of contributing factors as directed by R1's care plan. Despite these recommendations, the facility did not consistently assess or address the factors contributing to R1's repeated falls, the care plan was not updated to reflect the psychiatric recommendation for enhanced supervision.During an interview on 4/20/26 at 5:23 p.m., a family member (FM)-A stated she was not always informed about R1's fall incidents. FM-A reported R1 should be toileting every two hours while awake but this was not happening, especially when agency staff were working. FM-A explained staff did not pay attention to R1's needs, which my increase her behavior resulting in falls. FM-A stated she came to visit R1 on 4/18/26 and she was incontinent with urine, her WC was wet and smelling. R1 was sitting alone in the pod, and she had to call an NA to help R1. FM-A stated she did not report the incident to the nurse manager because they would not do anything to address the issue as always.During an interview on 4/20/26 at 1:03 p.m., a nursing assistant (NA)- A stated R1 tries to get up without help a lot and we don't always have someone right there to watch her. NA-A explained she had been walking in the hallway past R1's room when she observed R1 lying on the floor next to her bed, partially on the fall mat, on 3/17/26. NA-A stated R1's brief was on the bed, and R1 was incontinent of urine at the time. NA-A stated she immediately notified the nurse, who came to assess R1 before R1 was transferred back to bed using a mechanical lift. NA-A stated she was not aware of any new interventions added after R1's repeated falls.During an interview on 4/20/26 at 1:48 p.m., NA-B stated R1 had experienced multiple falls in her room and R1 needed to be checked every two hours to prevent further falls. NA-B reported R1 might be highly sensible to environmental factors such as noise, loud music, or light which could contribute to her repeated fall incidents. NA-B stated she did not recall any team discussions on the unit regarding R1's multiple falls or strategies to prevent recurrence. NA-B explained they were not aware of any new interventions added following R1's repeated falls.During an interview on 4/20/26 at 2:49 p.m., a licensed practical nurse (LPN)-A who served as R1's case manager stated R1 was one of the frequent fallers and she was aware of her multiple fall incidents. LPN-A reported she did not provide any education to the staff regarding R1's repeated falls or the corresponding interventions needed to ensure R1's safety. LPN-A stated she was not sure who updated R1's care plan following the falls. LPN-A reported she was unaware of R1's psychiatric mental health evaluation dated 2/25/26, which (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommended 24-hour supervision to ensure R1's safety. LPN-A confirmed that supervision levels were not increased despite R1's ongoing fall pattern.During an interview on 4/20/26 at 3:46 p.m., a registered nurse RN-A stated R1 had been falling a lot lately, but the care plan hadn't really changed. RN-A reported she completed the post fall evaluation on 2/26/26 for R1's unwitnessed fall on 2/18/26, during which R1's WC became stuck in a curve of the wall and R1 slipped out of WC, landing on pedals. RN-A stated she did not know what was decided during the interdisciplinary meeting regarding R1's falls. RN-A also reported she was unable to locate documentation in R1's medical record indicating whether a comprehensive assessment had been completed to guide an effective plan to prevent further falls. RN-A reported she was unaware of R1's psychiatric mental health evaluation dated 2/25/26, which recommended 24-hour supervision to ensure R1's safety. RA-A confirmed that supervision levels were not increased despite R1's ongoing fall pattern.During an interview on 4/20/26 at 4:16 p.m., the director of nursing (DON) stated R1 was a frequent faller, and the facility had been trying to work with FM-A to determine what interventions might work better for R1. The DON stated she did not know whether each fall had been reviewed to identify the root cause analysis with corresponding interventions to prevent recurrence. The DON stated she expected staff to complete a comprehensive assessment after multiple falls to determine to the root cause; however, she was unable to locate any comprehensive assessment in R1's medical record despite multiple falls. The DON reported she was unaware of R1's psychiatric mental health evaluation dated 2/25/26, which recommended 24-hour supervision to ensure R1's safety. The DON confirmed that supervision levels were not increased despite R1's ongoing fall pattern. The DON explained since R1's psychiatric mental health evaluation on 2/25/26, R1 had experienced seven fall incidents with no injuries. The DON confirmed staff did not update R1's care plan to reflect the psychiatric recommendations. The DON stated R1 should have had additional interventions added and that the facility did not follow through.Fall Prevention and Management Policy dated 6/5/23 indicated the care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. The policy also directed staff to complete a falls analysis when a resident has two or more falls, to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. Additionally, the policy indicated the facility will educate staff, residents, and families to promote a culture of safety, to keep residents safe and reduce falls risks.