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	05/21/2026

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 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** Based on observation, interview and document review the facility failed to ensure bruising and non-pressure wounds were adequately assessed and monitored for 2 of 3 resident (R2 and R3) reviewed for injuries of unknown origin.Findings include:R2R2's quarterly Minimum Data Set (MDS) dated [DATE], indicated R2 had moderate cognitive impairment, no skin impairment or dressing changes. R1 had diagnoses of peripheral vascular disease and hypertension.R2's medical record lacked documentation of R2's skin tear on his right outer wrist.During an interview on 5/20/26 at 11:16 a.m., R2 stated he got the skin tear on his right wrist from running into the door frame of his room but was not sure what it occurred. R2 stated a nurse had come in and put the dressing on a few weeks ago but he was not sure who the nurse was.During an observation on 5/20/26 at 11:17 a.m., R2 was seen with a bandage on his right wrist. Bandage was approximately 1 inch by 1 inch piece of gauze with a clear undated dressing over the top. During an observation on 5/20/26 at 2:35 p.m., registered nurse (RN)-A removed the bandage on R2's right wrist. R2 had a skin tear that measured 1 centimeter (cm) by 0.5 cm, with a scant amount of serosanguinous (pink to light red fluid) drainage, and no signs of infection.During an interview on 5/20/26 at 2:49 p.m., RN-A stated on 5/12/26, she placed a new wander guard on R2's right wrist and there was no injury at that time. RN-A stated someone had to have known about the skin tear on R2 because it had a dressing on it. RN-A stated she was not aware of the skin tear on R2 until 5/20/26, when state agency told RN-A. RN-A was not sure who put the dressing on R2's right wrist or when it was placed. R3R3's annual MDS dated [DATE], indicated R3 has severe cognitive impairment, R3 had diagnoses of hemiplegia (paralysis on side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke), vascular dementia, and epilepsy.R3's Skin Issue form dated 4/16/26, indicated R3 had a bruise on his lower back with no other details.R3's medical record lacked any further documentation or monitoring of R3's bruise on his lower back.During an interview on 5/20/26 at 10:37 a.m., R3 stated he was not aware he had a bruise on his back.During an interview on 5/21/26 at 9:13 a.m., RN-B stated if a new injury is found on a resident staff would be expected to assess the injury, document the findings in the resident's medical record, update the provider, and add monitoring of the area to the resident's orders. RN-B stated he found the bruising on R3's back and noted it had come from his lift sheet being bunched in a ball under his back. RN-B stated it slipped his mind to put monitoring in place for the bruise. RN-B forgot to put the full assessment of the bruise in R3's medical record.During an interview on 5/21/26 at 10:29 a.m., RN-A stated if staff find a new skin issue or bruise on a resident the staff would be expected to get measurements, gather information, and place the information in a risk management note as well as write a progress note in the resident's medical record. The staff would then be expected to put orders in the medical record for monitoring as well as any treatment needed and update the provider. RN-A stated she was not aware of R2's skin tear on his right wrist or R3's bruise on his back. RN-A stated they were unable to find which staff placed a dressing on R2's skin tear on his right wrist. RN-A stated she was not sure why the steps were not followed when a new skin issue or bruise was found.During an interview on 5/21/26 at 10:47 a.m., the director of nursing (DON) stated staff would be expected to fill out the skin form and follow the skin policy. If there was (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a new skin tear or bruising, there should have been orders to monitor those areas weekly and get orders from the provider as needed for treatments. The DON was not sure why the policy was not followed for R2's right wrist skin tear or R3's bruising on his back.During an interview on 5/21/26 at 11:02 a.m., the administrator stated the staff would be expected to fill out a risk management form, monitor the area, and contact the provider for any new skin tears or bruise found. The administrator stated the nurses at the facility are newer and would need some retraining on the skin policy.The facility New Skin Condition Policy revised 3/2024, indicated if any new skin issue was noted staff would document the area in the electronic medical record for continued monitoring, report open area to nurse manager, and obtain a physician's order for any new treatment initiated.