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	06/30/2026

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 interview and document review, the facility failed to comprehensively assess a change in bowel status and, if needed, implement interventions to prevent complication (i.e., obstruction, discomfort) for 1 of 3 residents (R3) reviewed. R3 developed consistent loose stools on 6/20/26 which were not evaluated or assessed, and R3 then admitted to the hospital on [DATE] with a potential bowel obstruction. In addition, the facility failed to update or communicate the results of completed medical testing (i.e., lab results, urinalysis) with the primary hospice team for 1 of 3 residents (R1) reviewed. R1 had multiple laboratory tests ordered on 6/5/26; however, the rationale for testing and subsequent test results were never shared with hospice to ensure appropriate coordination of care. Findings include: BOWELS NOT ASSESSED:R3's last completed and signed Bowel and Bladder Comprehensive, dated 4/29/25, identified R3 has being occasionally incontinent of bowel and needing extensive assistance with most activities of daily living (ADLs). The assessment left several sections blank with no recorded data present and outlined at the bottom that no changes to the care plan were made.R3's most recent Bowel and Bladder Comprehensive, dated 3/26/26, identified the evaluation remained, In Progress, and was not signed as completed. The evaluation identified multiple sections to record various data points including catheter use, restorative potential, bladder observation and bowel function. However, the sections for bowel function, labeled as Bowel Observations and Bowel Program Selection, were both left blank, and no recorded data was present.R3's annual Minimum Data Set (MDS), dated [DATE], identified R3 had short and long-term memory impairment but was always continent of bowel. The MDS recorded R3 as not being on a toileting program for bowels and having no constipation present. R3's corresponding Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) identified urinary incontinence as an actual problem which would be addressed in care planning. However, the completed CAA lacked any recorded data or review of R3's bowel status or bowel incontinence.R3's care plan, printed 6/30/26, identified R3's potential and actual problems along with interventions to address them. This outlined R3 had an activity of daily living (ADL) self-care deficit due to dementia and required assistance of two (A2) with a PAL lift for toileting and wore XL green briefs. Further, R3 had bowel incontinence and staff were to ensure he was placed on the toilet when being changed for the day, staff allowed him to sit and empty his bowels on the toilet, and staff toileted R3 every 4 hours and as needed (PRN). The section of the care plan which identified R3 as being incontinent of bowel was last updated 4/2026.R3's POC (Point of Care) Response History, dated 6/1/26 to 6/29/26, identified R3's recorded bowel movements in the EMR charting. The data recorded the size of movement along with its consistency. From 6/10/26 to 6/19/26, R3 had 15 recorded bowel movements with only four (4) recorded as loose/diarrhea. From 6/20/26 to 6/25/26, R3 had 10 bowel movements. However, now seven (7) of the ten were recorded as loose/diarrhea.R3's Medication Administration History (MAR), dated 6/2026, identified R3's provided medications for the month period. R3 was recorded as having PRN laxative medications available, such as Miralax, but there were no recorded administrations of these medications recorded for the month. R3's progress note, dated 6/25/26, identified R3's family member notified staff R3 was having a medical emergency and the nurse responded. R3 was found with a large amount of emesis on his (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

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	06/30/2026

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	chest and his abdomen very distended. R3 was transferred to the hospital via EMS. The note concluded, [Family] called with update . had a small bowel obstruction . Plan is to see surgeon in the morning.R3's corresponding hospital admission H&P, dated 6/26/26, identified R3 was admitted to the hospital from the emergency department (ED) for vomiting and abdominal distention. R3 had a PEG tube (Percutaneous Endoscopic Gastrostomy; a flexible feeding tube surgically placed through the abdominal wall directly into the stomach) in place for several years prior and a CT scan of the abdomen recorded, . distended with air and fluid, concerns for enteritis or partial obstruction.R3's medical record lacked evidence of any fully completed and signed bowel assessments since 4/2025 (over a year prior). Further, the record lacked evidence that R3's developed consistent loose stools (starting 6/20) were acted upon and assessed to determine what, if any, interventions were needed to reduce them or if more evaluation (i.e., notification to the provider) was needed.When interviewed on 6/30/26 at 9:03 a.m., nursing assistant (NA)-E stated bowel movements were tracked on a paper form and then entered to the computer charting. The NA who helped a resident when they had a bowel movement was responsible for charting it. The nurses would then assess the person and report to the NA how often they would be toileted. NA-E recalled working with R3 and stated he did not speak and would be incontinent of bowel every now and then only. NA-E stated they had noticed prior to R3 being hospitalized that his stools were loose and watery but were unsure if this was a change for him as they only worked casual shifts. In the past though, NA-E stated R3's stools were more on the soft, formed side. NA-E stated they were unsure if R3 used any laxative medications or not, and R3 had used tube feeding for several years prior to this hospitalization. Further, NA-E stated if they recognized a change in a resident then they'd report it to the nurse.When interviewed on 6/30/26 at 9:15 a.m., registered nurse (RN)-B explained they worked for a pool agency but had worked multiple shifts at the care center. RN-B stated they had worked with R3, and he was currently hospitalized . R3 had a tube feeding which was not brand new to him. RN-B stated they were not very sure of R3's bowel status as they only worked casually. However, if there was a change in bowel status the NA(s) had noticed, then they should report it, and the nurse would assess. RN-B stated a change in bowel movement consistency warranted an evaluation including bowel sounds and medication review as staff needed to determine where the change was coming from. RN-B stated they thought this process would be recorded in the progress notes or on a new Bowel and Bladder Comprehensive.On 6/30/26 at 10:05 a.m., a group interview was held with the director of nursing (DON), licensed practical nurse manager (LPN)-A, registered nurse case manager (RN)-C, and the RN/MDS coordinator (RN)-E. R3's medical record was reviewed and RN-E explained they complete a bowel evaluation using a look back report which captures the NA recorded data on bowel movements and continence. That information was then pulled to the MDS and completed on the Bowel and Bladder Comprehensive in the EMR. The RN was responsible for doing that evaluation, but an LPN could contribute. RN-E stated the facility had just recently changed to doing the comprehensive evaluations every quarter as prior they were only done annually. RN-E verified R3's last completed Comprehensive had the data for the bowel sections left blank adding they didn't finish it. They didn't complete it as they did not get along with R3's family member who was often present in his room. RN-E stated the missed data collection was a reason they had asked to adjust these evaluations to quarterly and not just annually. RN-E added it was to improve our cares. RN-E then reviewed R3's POC charting and stated the data showed a change in bowel consistency on 6/21/26 and wondered if anyone had reported it or evaluated it. LPN-A and RN-C both stated none of the aides had reported anything to them about R3 having loose stools. RN-E verified the medical record lacked evidence that the change of bowel status had been evaluated or assessed and explained any change like that should be acted upon to determine if the physician needs to be involved or not. DON stated they felt R3's hospitalization was likely unavoidable given the wife would want treatment options for a potential obstruction which the care center could not perform.A facility policy on bowel assessment or evaluation was requested; however, none was received. A provided Assessment Matrix, dated 6/26/26, identified each (continued on next page)

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	06/30/2026

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	assessment of the facility they completed and when to complete them. This identified nursing would complete the Bowel and Bladder Comprehensive on, Annual/Sig [sig change]. HOSPICE COORDINATION:R1's quarterly Minimum Data Set (MDS), dated [DATE], identified R1 had moderate cognitive impairment but no infections. A subsequent Discharge Return Anticipated MDS, dated [DATE], identified that R1 was admitted to the short-term general hospital.R1's Fax Cover Page, dated 6/5/26, identified the physician office faxed a series of orders to the care center from the medical doctor (MD). These included orders to draw multiple laboratory tests including a Complete Blood Count (CBC), metabolic panel (CMP), magnesium, phosphorus, and complete urinalysis (UA). The order listed a diagnosis for these as, Acute Confusion.R1's Health Laboratory (Results), dated 6/8/26, identified the tests were collected on 6/8/26 and showed the results. R1 was recorded with an elevated Creatinine, Blood Urea Nitrogen (BUN), and a decreased (low) red blood cell (RBC) count and hemoglobin. The UA showed, <10,000 colonies . Probable contaminant(s).R1's Hospice Visit Communication (record), dated 1/29/26 to 6/23/26, identified the registered nurse (RN) entries recorded on a paper format. R1 admitted to hospice on 1/29/26. This identified a total of nine (9) visits for June 2026 with the last entry on 6/23/26, Vitals low (BP, O2) Pulse [elevated] sent to ER per family. The notes lacked evidence that R1's completed labs on 6/8/26 were discussed or provided to hospice.R1's entire medical record, including progress notes, lacked evidence the laboratory testing was reported to the hospice agency for R1 to ensure hospice was involved in the decision making for R1 and to promote continuity of care.When interviewed on 6/29/26 at 11:57 a.m., hospice nursing assistant (NA)-B stated they had worked with R1 at the care center. R1 had several wounds on her legs and bottom and had become more tired as June 2026 progressed. NA-B stated R1's primary hospice nurse was RN-G who mostly helped with orders and treatments. NA-B stated there had been some issues with hospice care coordination at the care center over the past months but felt it was getting better lately as the hospice management had visited with the facility leadership prior about some issues. When interviewed on 6/29/26 at 12:23 p.m., hospice registered nurse (RN)-G stated they were R1's primary hospice nurse while R1 resided at the care center before her passing. R1's medical record was reviewed with RN-G who stated they were unaware R1 had lab testing completed on 6/8/26. RN-G added, We were not made aware of that. RN-G stated they would have liked to have been updated those tests were done and with the results and reiterated, I didn't know that happened. RN-G stated they did not have EMR access at the care center to see them without staff notification, but the care center was working on getting them access. The center and hospice relied on a lot of verbal communication to ensure continuity of care between them and RN-G stated there were times when some care things, like falls and this lab testing example, which didn't always get reported timely to hospice. RN-G stated a meeting was scheduled upcoming between hospice and the care center to discuss R1 (related to a missed antibiotic) and added they felt they were getting all the information on their other patients in the center adding further, I hope so.When interviewed on 6/29/26 at 1:02 p.m., RN-K stated the nurse manager or case manager would be the one responsible to update hospice with new orders or lab testing results. RN-K stated they had never been told or asked to do that prior as a floor nurse and reiterated the unit managers would handle it.On 6/29/26 at 2:02 p.m., a group interview was held with several members of the care center leadership present including the director of nursing (DON), administrator, licensed practical nurse manager (LPN)-A, and registered nurse case manager (RN)-C. It was explained that R1 was admitted to hospice in January 2026 for end-stage pulmonary hypertension and either of the nurse managers could update hospice with new orders, lab testing results, or other care-related items. R1's medical record was reviewed, and they explained that R1's family had called her MD on 6/4/26 with concerns for acute confusion which is what prompted the lab orders to come to the care center. LPN-A stated they could not recall if they visited with hospice about the lab orders and results or not, but RN-C then stated any communication with hospice should have a progress note completed in the record to show such happened. They verified hospice should have been updated with the orders and results for the lab (continued on next page)

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	06/30/2026

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	testing completed on 6/8/26 as hospice would make the decision to treat or not treat any abnormal results.A facility Hospice Services policy, dated 3/2022, identified the care center as responsible to designate a nurse to coordinate and supervise the services and be available to consult with hospice staff about the care plan. This included, Collaborate with Hospice staff regarding resident changes in condition or Physician orders. The policy added, Coordination of Care - Hospice and care center staff will communicate with one another regularly and as needed for each hospice patient.