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Form Approved OMB
No. 0938-0391

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	04/18/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 3 of 3 residents (R24, R34, and R46), reviewed and observed for self-administration of medications. Findings include: R24's significant change Minimum Data Set (MDS) dated [DATE], identified R24 was cognitively intact, and required assistance/supervision with activities of daily living (ADL's). During observation and interview on 4/15/24 at 6:12 p.m., a nebulizer machine was sitting on R24's nightstand and had an unknown solution sitting in nebulizer cup. R24 stated she self-administers nebulizer after staff sets it up for her and there are times when she forgets to do nebulizer treatment. R24 stated the solution in nebulizer cup was from this morning as she forgot to do nebulizer treatment. During record review on 4/16/24, the medication self-administration assessment, that was completed on 3/22/24, indicated R24 could not correctly administer nebulizer medications, R24 did not wish to self-administer medications and nursing staff was to store, administer and document all medications per medical doctor (MD) orders. R34's admission MDS dated [DATE], identified R34 was cognitively intact, and required assistance/supervision with ADL's. During observation on 4/15/24 at 2:18 a.m., R34 was sitting on the side of his bed, was holding nebulizer pipe in his mouth, nebulizer treatment running with clear solution noted in the nebulizer cup, no staff present in room. During observation and interview on 4/17/24 at 7:49 a.m., trained medication assistant (TMA)-A entered R34's room with morning medications. Prior to exiting room, TMA-A placed vial of nebulizer solution on R34's nightstand and left room. Once in hallway, TMA-A stated R34 liked to take the nebulizer treatment after breakfast so she would go back to R34's room in approximately one hour to set nebulizer treatment up for R34. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 4/17/24 at 8:29 a.m., TMA-A returned to R34's room to set up nebulizer treatment and stated that R34 already emptied the vial of nebulizer solution in the nebulizer cup and administered the nebulizer treatment. TMA-A stated R34 does that a lot and nursing staff will go in and make sure R34 completed nebulizer treatment. During record review on 4/17/24, the medication self-administration assessment, that was completed on 3/21/24, indicated R34 was not able to self-administer medications, R34 did not wish to self-administer medications and nursing staff was to store, administer and document all medications per MD orders. R46's admission MDS dated [DATE], identified R46 had intact cognition and required assistance with all ADL's. During observation on 4/15/24 at 12:00 p.m., an albuterol inhaler with a spacer attached was sitting on the over-the-bed table located on the side of R46's recliner next to the window. During observation on 4/16/24 at 2:12 p.m., R46 was sitting in his recliner with the albuterol inhaler sitting on over-the-bed table next to R46's recliner. During observation on 4/18/24 at 8:17 a.m., R46 was sitting in recliner with the albuterol inhaler sitting on over-the-bed table next to R46's recliner. During observation on 4/18/24 at 9:02 a.m., R46 was holding the inhaler in his hand, moving it away from his mouth and placed in on over-the-bed table next to recliner. During record review on 4/17/24, the medication self-administration assessment completed on 4/1/24, indicated R46 could not correctly administer inhalant medications, R46 did not wish to self-administer medications and nursing staff was to store, administer and document all medications per MD orders. During interview on 4/18/24 at 1:50 p.m., TMA-B stated nursing staff would set up nebulizer with solution in the nebulizer cup and leave it on the nebulizer for R24 to self-administer at a later time. TMA-B stated nursing staff will have to remind R24 to do nebulizer treatment as R24 tends to forget to perform treatment. TMA-B stated she sets up nebulizer with solution in the nebulizer cup and leaves it on the nebulizer for R34 to self-administer at a later time. TMA-B stated R34 would turn on machine, do treatment and then placed nebulizer pipe on nightstand. TMA-B would go in to ensure that R34 did treatment and would then wash nebulizer equipment. TMA-B confirmed that R46 had an albuterol inhaler sitting on over-the-bed table next to recliner and stated she had seen R46 use inhaler independently. TMA-B confirmed R24, R34 and R46 did not have a self-administration order. During interview on 4/18/24 at 2:15 p.m., licensed practical nurse (LPN)-B stated nursing staff sets up R24 and R34's neb solution for R24 and R34 to self-administer at a later time. LPN-B confirmed R46 had an albuterol inhaler sitting on the over-the-bed table next to recliner and she saw R46 use inhaler independently. LPN-B confirmed R24, R34 and R46 did not have a self-administration order. During interview on 4/18/24 at 2:22 p.m., TMA-A confirmed R46 had an albuterol inhaler sitting on the over-the-bed table next to recliner and stated she has seen R46 use inhaler independently. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/18/24 at 2:23 p.m., TMA-A stated nursing staff sets up R24 and neb solution for R24 to self-administer at a later time. During interview on 4/18/24 at 3:07 p.m., assistant director of nursing (ADON) stated in order for a resident to be able to self-administer medications, a self-administration assessment must be completed. If the resident is determined to be able to self-administer medications after completed assessment, the nurse would notify the provider to obtain an order. ADON stated it is important for a resident to be assessed to ensure that resident is able to administer properly, are receiving the correct medication and dose and that there is appropriate storage. ADON confirmed that R24, R34 and R46 did not have an order to self-administer medications. The facility Self-Administration of Medications policy, dated 1/8/18, indicated the facility will ensure any resident that wishes to self-administer medications will be assessed, and the Interdisciplinary Team (IDT) will determine if it is appropriate for that individual resident. A. All residents will be asked if they wish to self-administer their medications upon admission. B. If the resident wishes to self-administer medications, they will be assessed for their ability to safely self-administer their medications. A Self-Administration of Medications (SAM) assessment will be completed and reviewed by the IDT. This assessment will include: a. Cognitive status, b. Physical status, c. Which medications are appropriate to be self-administered. d. Where the medication will be stored safely, e. How the nursing staff will monitor the medication's use, and f. How it will be documented. C. If the resident is clinically appropriate to self-administer medications, interventions will be put into place to accommodate the resident's wishes. D. A periodic re-assessment by the IDT of the continued appropriateness of the self-administration will be completed, and the decision to continue the self-administration of medications will be based on changes in the resident's medical and decision-making status. E. If self-administration is determined not to be sage, the IDT will consider, based on the assessment of the resident's abilities, options that allow the resident to actively participate in the administration of their medications to the extent that is safe. F. Resident will be permitted to retain medications in their rooms if approved by the IDT and ordered by the attending physician. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. Nursing staff will ensure the Electronic Medical Record (EMR) and care plan reflects the resident's self-administration of medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40938 Based on interview and document review, the facility failed to ensure resident's family and/or representative were updated timely for a change in condition related to resident death for 2 of 2 residents (R203 and R205) reviewed for notification of change. Findings include: Review of R203 electronic health record (EHR) identified a progress note dated [DATE], indicated at 9:45 p. m. R203 was found unresponsive with no vital signs, call was placed to hospice agency at 9:51 p.m. However, R203's EHR failed to indicate family/resident representative was updated regarding R203 passing away. When interviewed on [DATE] at 1:28 p.m., family member (FM)-B stated the facility did not contact the family when he was declining the day he died , family was informed two hours after he had passed away. FM-B stated family was told someone had sat with R203 while he was declining but there was no phone call made. When interviewed on [DATE], at 2:46 p.m. assistant director of nursing (ADON) stated typically hospice would update the family after a visit. ADON would attempt to locate notification to family regarding R203 passing away however, no documentation regarding family notification was provided. When interviewed on [DATE], at 1:06 p.m. FM-C stated facility called on [DATE] at about 2:30 p.m. to report R205 had a fall, received cardio pulmonary resuscitation (CPR) about 1:00 p.m., R205 passed away about 1:40 p.m. FM-C further stated family had not been informed R205 had facial injuries from the fall until the funeral had called them about bruising. FM-C identified in [DATE] R205 was sent to the hospital, family was not informed until the hospital called 13 hours later that R205 was being sent to a different hospital. Progress note dated [DATE], indicated R205 reported weakness earlier throughout the day was not feeling well, had shortness of breath, was unable to bear weight and respirations were increased. Progress note failed to identify notification to family of change in condition. Progress note dated [DATE], indicated R205 was out of the facility, was transported [DATE], to the hospital via ambulance on the PM shift. R205's EHR failed to identify family was notified R205 had been transported to the hospital. Review of R205's EHR identified progress note dated [DATE], R205 was found face down on the floor in a pool of blood with electric recliner tilted up in the air. CPR was started and 911 was called. emergency medical services (EMS) arrived about 1:20 p.m. EMS called the time of death at about 1:50 p.m., provider and coroner were called at 4:45 p.m., funeral home contacted at 3:40 p.m., family updated, however progress note failed to identify when the family was notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on [DATE], at 1:35 p.m. registered nurse (RN)-A sated R205 did not have a change in condition until found on the floor. R205 had been found face first on the floor with cut on nose bleeding from the cut. Family was updated, could not recall what time but was after CPR was started. RN-A did not recall family being notified of facial injuries due to the fall. During interview on [DATE], at 2:53 p.m. ADON stated family was notified after CPR was stopped. ADON stated she would not have expected someone to notify family during the emergency, a staff member could have stepped away after EMS arrived and took over however this was not done. ADON was not aware of family was not notified of January hospitalization notification. Facility policy Notification of Significant Changes reviewed [DATE], indicated charge nurse would immediately inform the resident representative for significant change situations including any accident involving the resident which resulted in injury, a deterioration in health. decision to transfer to another provider or death of a resident.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40938 Based on interview and document review, the facility failed to ensure the long-term care (LTC) Ombudsman was notified of hospitalization s (i.e., facility-initiated discharges) for 5 of 6 residents (R11, R15, R24, R34, and R51) reviewed for hospitalization . Findings include: R11's significant change Minimum Data Set (MDS) dated [DATE], identified R11 as medically complex with intact cognition and diagnoses of hypertension, schizotypal disorder, pain in right leg, polymyalgia rheumatica, localized edema, morbid obesity due to excess calories, insomnia due to other mental disorder, depression, and urinary tract infection (last 30 days). R11's progress noted dated 3/7/24 indicated resident temperature was elevated and he was experiencing pain. Resident requested to be transported to the emergency room (ER) due to increased pain to right lower extremity (RLE). R11's progress noted dated 3/8/24 indicated resident admitted to the hospital with dehydration, urinary tract infection (UTI), pain, and frequent falls. R11 was admitted to CHI St Gabriel's Hospital 3/7/24-3/11/24. Prior to transfer R11 signed a Bed Hold Election and Hospital Transfer form. R11's progress noted dated 3/11/24 indicated resident returned from the hospital after being treated with intravenous (IV) antibiotics. However, R11's medical record lacked evidence the LTC Ombudsman had been notified of hospitalization . R15's annual Minimum Data Set (MDS) dated [DATE], identified R15 had intact cognition and required assistance with all activities of daily living (ADL)'s. R15's progress note, dated 3/1/24, identified R15 was experiencing increased shortness of breath and low oxygen saturations. R15's progress note, dated 3/1/24, identified R15 was readmitted to the nursing home with a diagnosis of Influenza A. However, R15's medical record lacked evidence the LTC Ombudsman had been notified of transfer. R24's significant change Minimum Data Set (MDS) dated [DATE], identified R24 was cognitively intact, and required assistance/supervision with activities of daily living (ADL's). R24's progress noted dated 2/12/24, identified R24's blood pressure had gone extremely low while at an appointment outside of facility and was sent to the emergency department (ED) for evaluation. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	R24's progress note, dated 2/15/24, identified R24 was readmitted to the nursing home after being hospitalized for UTI and hypotension. However, R24's medical record lacked evidence the LTC Ombudsman had been notified of hospitalization . R34's admission MDS dated [DATE], identified R34 was cognitively intact, and required assistance/supervision with ADL's R34's progress note, dated 4/5/24, identified R34's stoma was edematous (swollen) and protruding and was sent to the ED for evaluation. R34's progress note, dated 4/5/24, identified R34 was readmitted to the nursing home after being evaluated. However, R15's medical record lacked evidence the LTC Ombudsman had been notified of transfer. R51s admission minimum data set (MDS) dated [DATE], indicated R51 was cognitively intact, and required moderate staff assist with activities of daily living (ADL)'s. Diagnoses included coronary artery disease, heart failure, respiratory failure, hypertension R51's progress noted, dated 2/04/2024, identified R51 complained of a worsening headache, with dizziness, developed confusion and difficulty finding words. R51 ws transferred to the hospital. However, R51's medical record lacked evidence the LTC Ombudsman had been notified of transfer. On 4/15/24 at 4:13 p.m., LTC Ombudsman sent an email to surveyor stating that she had not received any notices of transfers or discharges from the facility for over a year. Ombudsman stated she had spoken to the administrator and activity director about this in the past. During interview on 4/16/24 at 1:42 p.m., nurse consultant (NC) stated the facility could not locate records to indicate the LTC Ombudsman had been notified of transfers and/or discharges. The Transfer and Discharge from Facility policy was requested but was not received. 47638 48013

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to provide the resident or their representative a written bed hold policy at the time of hospital transfer for 1 of 6 residents (R24) who was reviewed for hospitalization . Findings include: R24's significant change Minimum Data Set (MDS) dated [DATE], identified R24 was cognitively intact, and required assistance/supervision with activities of daily living (ADL's). R24's progress notes indicated R24 was hospitalized on [DATE] and returned to the facility on [DATE]. R24's medical record lacked evidence of a bed hold was provided at the time of transfer for hospitalization . During an interview on 4/18/24 at 3:07 p.m., assistant director of nursing (DON) expected when a resident was transferred out of the facility a bed hold was initiated by the cart nurse. DON stated she expected the case manager to follow up to determine if the resident wanted to continue holding the bed. DON confirmed that she could not find communication with the resident in regard to a bed hold for R24 hospitalization . DON stated it is important for the resident to be aware of what they may have to pay for and that they have a spot to come back to. The facility Bed Hold Election & Hospital Transfer policy, dated 11/16/23, indicated the facility will assure each resident, responsible person or legal representative is provided the option to hold their bed during a hospitalization or a therapeutic leave. In case of an emergency transfer to the hospital, the facility will send a copy of the notice with the other transfer papers accompanying the resident to the hospital. A phone call will be made to the responsible party, notifying them of the emergency transfer and the bed hold policy. The nurse will document in a progress note that the appropriate party was informed of the bed hold policy and the decision regarding the bed hold. A copy of the bed hold policy indicating the date and to whom the bed hold policy was discussed will be sent in the mail within 24 hours. In the case of a weekend transfer, the copy will be sent the first working day following the weekend. Copies of the transfer notice will be also sent to the ombudsman when practicable, no less than monthly.

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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** 40938 Based on interview and document review, facility failed to ensure provider orders were followed to monitor vital signs for 1 of 1 residents (R51) reviewed for following physician's orders. In addition, the facility failed to obtain a provider order for a lap positioning belt for 1 of 1 resident (R29) reviewed for use of a positioning belt. Findings include: R51's Resident Face Sheet printed 4/18/24, indicated R51 had several diagnoses which included arteriosclerotic heart disease (narrowing of arteries), hypertension, congestive heart disease, nontraumatic subarachnoid hemorrhage (brain bleed). Review of R51's electronic health record (EHR) identified R51 was seen by nurse practioner (NP) on 2/2/24, NP ordered vital signs three times daily for increased risk of brain bleed. R51's EHR failed to reveal vital signs completed three times daily for 3 days. A review of residents closed hard chart failed to reveal vital signs were completed per order. During interview on 4/17/24, at 11:10 a.m. nurse consultant stated that if there was an order for vital signs they would be in the EHR. When interviewed on 4/18/24, at 2:40 p.m. Assistant director of nursing (ADON) stated vital signs were not recorded on a paper flowsheet. Vital signs would be in the vital sign area of the EHR. ADON reviewed electronic medication administration record (EMAR), pink boxes were located in the boxes for documenting the vital signs in the order. ADON stated pink box indicated missed documentation. At 4:31 p.m. ADON returned stated she was not able to locate vital signs for R51 for the 3 days ordered by provider. A provider order policy was requested but not received. 48013 R29's quarterly Minimum Data Set (MDS) dated [DATE], identified R29 had intact cognition and required assistance with all activities of daily living (ADL)'s. R29's diagnoses included cerebral palsy and neuromuscular scoliosis (a type of scoliosis caused by neurological conditions that weaken the muscles or nerves around the spine). R29's care plan, dated 8/27/22, identified that R29 preferred to wear a seat belt when in his electric wheelchair. R29's restrictive device assessment, dated 8/21/23, identified that R29 utilized a lap positioning belt and was able to undo belt when he wanted it undone. R29's physician orders, print date of 4/16/24, lacked evidence on order for the lap positioning seatbelt. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/18/24 at 5:33 p.m., assistant director of nursing (ADON) confirmed that facility could not locate a physician order for lap positioning seatbelt and that an physician's order was needed for the lap positioning seatbelt. ADON stated facility needed a physician's order to direct care of the resident to the facility. A provider order policy was requested but not received.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview, and document review the facility failed to comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for 1 of 1 (R24) residents reviewed who's diagnoses included post-traumatic stress disorder (PTSD). Findings include: R24's significant change Minimum Data Set (MDS) dated [DATE], identified R24 was cognitively intact, and required assistance/supervision with activities of daily living (ADL's). R24's diagnoses included PTSD, anxiety disorder, and depression. R24's care plan dated 2/21/24 lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization related to PTSD. R24's electronic health record (EHR) consisted of a trauma assessment that was completed on 2/9/24, which indicated R24 had trauma in her past that affected her daily. Medications and talking to others helped her cope with her trauma. During interview on 4/17/24 at 11:43 a.m., nurse practitioner (NP)-A stated R24 had a significant history of trauma, PTSD and had multiple suicide attempts which affects her daily life. During interview on 4/18/24 at 1:50 p.m., trained medication assistant (TMA)-B stated that she was not aware of any past trauma in R24's life and/or of PTSD diagnoses. During interview on 4/18/24 at 2:15 p.m., licensed practical nurse (LPN)-B stated that she was not aware of any past trauma in R24's life and/or of PTSD diagnoses. During interview on 4/18/24 at 2:23 p.m., TMA-A stated that she was not aware of any past trauma in R24's life and/or of PTSD diagnoses. During an interview on 4/18/23 at 3:07 p.m., assistant director of nursing (ADON) stated that when a resident is admitted , they are asked about past trauma and trauma informed care questionnaire would be completed. ADON stated R24's care plan should have included behavior monitoring, PTSD triggers, how staff would avoid those triggers and interventions to be used if R24 was triggered. ADON confirmed R24 did not have behavior monitoring or a care plan that addressed R24's past trauma. A facility policy trauma informed care dated 9/11/23 indicated the facility would provide guidance to care center staff on the principles and care practices that guide trauma informed care that accounted for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Falls Care Center	1200 First Avenue Northeast Little Falls, MN 56345

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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 0756

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40938

Based on interview and document review, the facility failed to ensure consulting pharmacist identified irregularities in the monthly drug regimen reviews for 3 of 5 residents (R11, R21 and R34) reviewed for unnecessary medications.

Findings include:

R11's significant change Minimum Data Set (MDS) dated [DATE], identified R11 as medically complex with intact cognition and diagnoses of hypertension, schizotypal disorder, pain in right leg, polymyalgia rheumatica, localized edema, morbid obesity due to excess calories, insomnia due to other mental disorder, depression, and urinary tract infection (last 30 days).

R11's provider order dated 8/30/23- included monthly orthostatic blood pressure (BP) monitoring while on trazodone to be obtained on the 14th of every month.

R11's order dated 11/27/23- included trazodone HCL 100mg tablet. One tablet by mouth every day at 7pm-10pm.

R11's vital sign documentation listed one orthostatic BP obtained 2/14/24. No additional readings were recorded from the 8/30/23 to 4/18/24.

R11's medical record lacked evidence of monitoring for hypotension, done by taking orthostatic blood pressures. R11's medical record also lacked evidence this recommendation was made by the pharmacy consultant.

R21's quarterly MDS dated [DATE], indicated R21 had severe cognitive impairment and was dependent on staff for cares. R21 diagnoses included cardiovascular disease, autistic disorder, adjustment disorder, hypomagnesemia , diabetes, and depression.

R21's physician orders review dated 2/29/24, identified orders for the psychotropic medications lorazepam (antianxiety) for anxiety, and paliperidone (antipsychotic) for anxiety.

R21's medical record was reviewed and lacked evidence orthostatic blood pressures had been obtained for R21. R21's record also lacked evidence of pharmacy review recommendation for orthostatic blood pressure to be completed.

R34's admission MDS dated [DATE], identified R34 was cognitively intact, and required assistance/supervision with ADL's. R34's diagnosis included type two diabetes mellitus, chronic obstructive pulmonary disease, other specified symptoms and signs involving the digestive system and abdomen, anxiety disorder, moderate protein-calorie malnutrition, alcohol abuse and long-term use of anticoagulants as well as daily use of antipsychotic and antianxiety medications.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34's Physician Order Review dated 4/17/24, identified orders for the psychotropic medications olanzapine (antipsychotic) for alcohol abuse with a start date 3/20/24 and Hydroxyzine HCL (antianxiety) for anxiety disorder with a start date of 3/18/24. R34's care plan dated 4/3/24, indicated the use of mood-altering medications with a goal to be free of drug related complications. R34's medical record lacked evidence of monitoring for hypotension, which is done by taking orthostatic blood pressures. R34's medical records also lacked evidence of an initial assessment for abnormal involuntary movements (AIMS). During interview on 4/17/24 at 11:10 a.m., nurse consultant (NC) stated that if there was an order for neuros or orthostatic blood pressures, the vitals obtained would be displayed on the vitals screen in resident's electronic health record (EHR). During interview on 4/18/24 at 10:28 a.m., Pharm D stated an AIMS assessment is done as a baseline with the start of an antipsychotic or admission of resident and then every six months. The pharm D stated that an AIMS assessment is important to monitor/assess for side effects of tardive dyskinesia (condition affecting the nervous system, often caused by long-term use of some psychiatric drugs) and it is important to get a baseline AIMS assessment to see what side effects the resident may be experiencing. Then staff monitor to assess if those side effects are worsening from the medications. The Pharm D stated he had missed recommending the facility complete an AIMS when R34 was admitted to the facility with an antipsychotic. The pharm D stated he generally does not recommend orthostatic blood pressures to the facility on his monthly reviews for residents receiving psychotropic medications. PharmD stated he would review resident's blood pressures and would reach out to the facility with any concerns. The pharm D stated the facility should be monitoring orthostatic blood pressures for residents receiving psychotropic medications as hypotension is a side effects for those medications. The Pharm D confirmed that R34 did not have an order for orthostatic blood pressured. The pharm D stated he had missed recommending this monitoring to the facility. During interview on 4/18/24 at 2:26 p.m., licensed practical nurse (LPN)-A stated that if orthostatic blood pressures are ordered, they would be documented in the vitals section in the EHR. During interview on 4/18/24 at 3:07 p.m., assistant director of nursing (DON) stated the facility relies on the Pharm D recommendations for monitoring and assessments of medications. The DON confirmed R34's medical record lacked any orthostatic blood pressure monitoring and AIMS assessments. The DON stated the importance of orthostatic blood pressures and AIMS assessments is to make sure that the resident is not having any adverse effects from the prescribed medications. The DON confirmed R34's medical record lacked any recommendations regarding orthostatic blood pressures and or AIMS assessment from the Pharm D. During interview on 4/18/24 at 5:52 p.m., NC stated the psychotropic medication policy does not address/include monitoring orthostatic blood pressures. The facility Psychotropic Medications policy, dated 9/11/23, indicated the facility would ensure appropriate use, evaluation, and monitoring of medications. Facility would ensure the therapeutic use of and to minimize the risks associated with psychotropic medications. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47638 48013

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NAME OF PROVIDER OR SUPPLIER: Little Falls Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1200 First Avenue Northeast Little Falls, MN 56345	

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40938 Based on interview and document review, the facility failed to ensure monitoring for potential cardiovascular and neurological adverse effects with use of psychotropic medications for 3 of 5 residents (R11, R21 and R34) reviewed for unnecessary medications. Findings include:. R11's significant change Minimum Data Set (MDS) dated [DATE], identified R11 as medically complex with intact cognition and diagnoses of hypertension, schizotypal disorder, pain in right leg, polymyalgia rheumatica, localized edema, morbid obesity due to excess calories, insomnia due to other mental disorder, depression, and urinary tract infection (last 30 days). R11's signed provider order dated 8/30/23- included monthly orthostatic blood pressure (BP) monitoring while on trazodone to be obtained on the 14th of every month. R11's order dated 11/27/23- trazodone HCL 100mg tablet. One tablet by mouth every day at 7pm-10pm. R11's vital sign documentation listed one orthostatic BP obtained 2/14/24. No additional readings were recorded from the 8/30/23 to 4/18/24. R11's medical record lacked evidence of monitoring for hypotension, done by taking orthostatic blood pressures. R11's medical record also lacked evidence of a recommendation by the pharmacy consultant to routinely monitor for hypotension. R21's quarterly MDS dated [DATE], indicated R21 had severe cognitive impairment and was dependent on staff for cares. R21 diagnoses included cardiovascular disease, autistic disorder, adjustment disorder, hypomagnesemia , diabetes, and depression. R21's physician orders review dated 2/29/24, identified orders for the psychotropic medications depakote (antidepressant) for pseudobulbar affect anxiety disorder (uncontrollable and inappropriate laughing or crying), lorazepam (antianxiety) for anxiety, and paliperidone (antipsychotic) for anxiety. R21's medical record was reviewed and lacked evidence orthostatic blood pressures had been obtained for R21. R21's medical record lacked evidence of pharmacy review recommendation for orthostatic blood pressure to be completed by facility. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R34's admission Minimum Data Set (MDS) dated [DATE], identified R34 was cognitively intact, and required assistance/supervision with ADL's. R34's diagnosis included type two diabetes mellitus, chronic obstructive pulmonary disease, other specified symptoms and signs involving the digestive system and abdomen, anxiety disorder, moderate protein-calorie malnutrition, alcohol abuse and long-term use of anticoagulants as well as daily use of antipsychotic and antianxiety medications. R34's Physician Order Review dated 4/17/24, identified orders for the psychotropic medications Olanzapine (antipsychotic) for alcohol abuse with a start date 3/20/24 and Hydroxyzine HCL (antianxiety) for anxiety disorder with a start date of 3/18/24. R34's care plan dated 4/3/24, indicated the use of mood-altering medications with a goal to be free of drug related complications. R34's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for R34. R34's medical record lacked evidence of monitoring for hypotension, which is done by taking orthostatic blood pressures and completing AIMS assessments on a frequency normally recommended by the pharmacy consultant (Pharm D). R34's medical record lacked evidence of assessment for abnormal involuntary movements (AIMS). During interview on 4/18/24 at 10:28 a.m., Pharm D stated an AIMS assessment is done as a baseline with the start of an antipsychotic or admission of resident and then every six months. The pharm D stated that an AIMS assessment is important to monitor/assess for side effects of tardive dyskinesia and that it is important to get a baseline AIMS assessment to see what side effects the resident may be experiencing and then staff came monitor to assess if those side effects are worsening from the medications. The Pharm D stated he had missed recommending the facility complete an AIMS when R34 was admitted to the facility with an antipsychotic. The pharm D stated he generally does not recommend orthostatic blood pressures to the facility on his monthly reviews for residents receiving psychotropic medications. The pharm D stated the facility should be monitoring orthostatic blood pressures for residents receiving psychotropic medications as hypotension is a side effects for those medications. The pharm D confirmed that R34 did not have an order for orthostatic blood pressured. The pharm D stated he had missed recommending this monitoring to the facility. During interview on 4/17/24 at 11:10 a.m., nurse consultant (NC) stated that if there was an order for neuros or orthostatic blood pressures, the vitals obtained would be displayed on the vitals screen in resident's electronic health record (EHR). During interview on 4/18/24 at 2:26 a.m., licensed practical nurse (LPN)-A stated that if orthostatic blood pressures are ordered that they would be documented in the vitals section in the EHR. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 4/18/24 at 3:07 p.m., assistant director of nursing (DON) stated the facility relies on the Pharm D recommendations for monitoring and assessments of medications. The DON confirmed R34's medical record lacked any orthostatic blood pressure monitoring and AIMS assessments. The DON stated the importance of orthostatic blood pressures and AIMS assessments is to make sure that the resident is not having any adverse effects from the prescribed medications. The DON confirmed R34's medical record lacked any recommendations regarding orthostatic blood pressures and or AIMS assessment from the Pharm D. During interview on 4/18/24 at 5:52 p.m., NC stated the psychotropic medication policy does not address/include monitoring orthostatic blood pressures. The facility Psychotropic Medications policy, dated 9/11/23, indicated the facility would ensure appropriate use, evaluation, and monitoring of medications. Facility would ensure the therapeutic use of and to minimize the risks associated with psychotropic medications. 47638 48013

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47638 Based on document review and interview, the facility failed to submit complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data, during 1 of 1 quarters reviewed (Quarter 1), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: During review, Payroll Based Journal (PBJ) [NAME] Report 1705D identified excessively low weekend staffing was triggered. During review, staffing schedules and daily postings for the weekends during this quarter did not indicate staffing was excessively low therefore the data submitted in the PBJ to CMS was inaccurate. During interview on 4/18/24 at 3:25 p.m., scheduler (S)-E stated she does not submit this information and was not sure who does. S-E was able to provide additional documentation confirming staffing level was not excessively low. During interview on 4/18/24 at 4:02 p.m., Administrator stated the information is submitted by the corporate office for all 15 of their facilities. Administrator submits facility data to corporate office prior to submission. Administrator stated he was informed of a sister facility who was recently surveyed and cited for this issue as well. The corporate office determined that a data entry error was made at the time of submission, and this affected all facilities, and has been corrected prior to submission of the data for the next quarter. Administrator was advised that a correction had been submitted after the discovery of the error. There was no policy related to PBJ entries available by the end of the survey.

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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 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48013 Based on interview and document review the facility failed to review and/or revise the infection control programs policies and procedures at least annually. This had the potential to affect all 51 residents, all staff, and all visitors at the facility. Findings include; Review of the facility's infection control policies was conducted on 4/17/24. -The facility policy titled Infection Surveillance had an effective date of 3/1/17, with a reviewed/amended date of 5/8/17. -The facility policy titled Infection Prevention and Control Program had an effective date of 3/1/17, with a reviewed/revised date of 12/14/22. -The facility policy titled COVID-19 Vaccination had an effective date of 12/28/20, with a reviewed/amended date of 9/29/22. -The facility policy titled Resident Tuberculosis Prevention and Control had an effective date of 3/24/17, with a reviewed/revised date of 7/1/19. -The facility policy titled Antibiotic Stewardship Program had an effective date of 6/12/17, with a reviewed/revised date of 7/1/19 -The facility policy titled Standard Precautions had an effective date of 3/1/17, with a reviewed/revised date of 5/8/17. -The facility policy titled Transmission Based Precautions had an effective date of 3/1/17, with a r reviewed/revised date of 6/7/17. -The facility policy titled Infection Prevention and Control Staff Training had an effective date of 3/30/17, with a reviewed/revised date of 6/5/17. -The facility policy titled COVID-19 Testing had an effective date of 9/18/20, with a reviewed/amended date of 2/26/21. -The facility policy titled Resident Influenza had an effective date of 3/22/17, with a reviewed/revised date of 6/5/17. -The facility policy titled Employee Infectious Illness Guidelines had an effective date of 3/22/17, with a reviewed/amended date of 6/5/17. (continued on next page)

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Many	During interview on 4/18/24 at 1:01 p.m., the infection preventionist (IP) stated the infection control policies are corporate policies and are reviewed by corporate. IP confirmed these are the policies the facility followed. IP stated that she was not aware of the facility reviewing them individually annually. During interview on 4/18/24 at 3:07 p.m., the assistant director of nursing (ADON) stated the infection control policies are corporate policies and are reviewed by corporate. ADON confirmed these are the policies the facility followed. ADON stated that she was not aware of the facility reviewing them individually annually. During interview on 4/18/24 at 4:37 p.m., nurse consultant (NC) stated policies are reviewed and amended by the quality team as needed when there are changes and then are sent to get approval from corporate leadership. NC stated that when a policy is reviewed/amended/revised, the date at the bottom of the policy would be updated with the reviewed date. NC confirmed the date of the bottom of the above policies were the review date. NC stated another quality nurse recently did a team meeting with all corporate facilities director of nursing and administrators with 14 policies being reviewed with them and confirmed that none of the policies reviewed were infection control related.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure 3 of 5 residents (R15, R24 and R34) reviewed for immunizations were offered and/or provided the Influenza vaccine and/or the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over [AGE] years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after [AGE] years old. R15's face sheet, dated 4/18/24, indicated he was [AGE] years old. The immunization record, dated 4/16/24, indicated he received a PCV13 on 10/18/17 followed by the PPSV23 on 5/21/19. During review of the immunization record in the electronic health record (EHR), the record indicated R15 was offered and declined the PCV20 on 3/29/24, was offered and declined the Influenza vaccine on 9/18/23. No declination form, education, or progress note was found in R15's EHR for the PCV20 or Influenza vaccination. R24's face sheet, dated 4/18/24, indicated she was [AGE] years old. The immunization record, dated 4/16/24, indicated she received a PCV13 on 12/28/16. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 1 year after the last pneumococcal dose. The record lacked evidence that R24 was offered or received PCV20. R34's face sheet, dated 4/18/24, indicated he was [AGE] years old. The immunization record, dated 4/16/24, indicated he received a PPSV23 on 3/7/14 followed by the PPSV23 on 11/11/21. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 1 year after the last pneumococcal dose. The record lacked evidence that R34 was offered or received PCV20. During interview with infection preventionist (IP), on 4/18/2024 at 1:01 p.m., the IP indicated immunizations are reviewed upon admission. IP stated IP used the Centers of Disease Control and Prevention (CDC) pneumococcal vaccine recommendations, dated 2/16/2022 for eligibility of pneumococcal immunizations. IP verified R24 and R34's pneumococcal immunizations as listed above and they had not been offered or provided education on the PCV20. IP verified there had been no shared clinical decision making with the provider regarding pneumococcal immunizations for R24 or R34. IP stated it was important to ensure residents are offered all available vaccinations to prevent the risk of developing symptoms to lead to acute illness. (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	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Resident Immunizations with a review date of 9/29/23 indicated all resident will be offered vaccinations based on the Centers for Disease Control (CDC) recommendations and physician orders. For adults aged 65 or older that have received PCV13 only, wait one year and administer one dose of pCV20 or complete the recommended PPSV23 series. For adults aged 65 or older who have previously received more than one dose of the PPSV23 vaccine, wait at least a year after previous vaccine, before giving PCV15 or PCV20. Documentation of evidence that the resident or resident's representative was provided education regarding the benefits and side effects of influenza and pneumococcal immunizations will be put on file.