

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 07/30/2026
NAME OF PROVIDER OR SUPPLIER Little Falls Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement a system to ensure medications were consistently acquired, received, and administered as ordered for 3 of 3 residents (R20, R4, R22) reviewed. As a result, R20 did not receive hydromorphone (synthetic opioid/narcotic) for seven days and pregabalin (anticonvulsant to treat nerve pain) for four days. This resulted in actual harm when R20 experienced severe withdrawal symptoms. Findings include: R20 R20's annual Minimum Data Set (MDS), dated [DATE], indicated R20 was cognitively intact. Diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes with diabetic neuropathy (nerve damage in legs and feet), anxiety, and moderate protein-calorie malnutrition, and R20 received scheduled pain medication regimen. R20's care plan revised 9/10/25, indicated R20 had acute/chronic pain and interventions included administration of pain medications per order. During an interview on 7/29/26 at 2:35 p.m., R20 stated he went without his hydromorphone and pregabalin for days and went into withdrawal. R20 stated he was shaking, short of breath (SOB), sweating, nauseous, heart racing, and was in horrible pain. R20 stated he didn't eat for two days, wanted to crawl out of my own skin and it was a miserable four days. R20's Order Summary Report dated 6/3/26, indicated R20 had been taking the following long-term: hydromorphone HCL 4 milligrams (mg) by mouth two times a day (BID) related to other chronic pain was ordered 10/27/24 pregabalin 100mg by mouth three times a day (TID) for chronic pain was ordered 6/25/25 R20's July 2026 Medication Administration Record (MAR) indicated R20 was not administered medications as follows: hydromorphone 4mg 7/21 bedtime (HS) dose 7/22 morning (AM) and HS doses 7/23 AM and HS doses 7/24 AM and HS doses 7/25 AM and HS doses 7/26 AM and HS doses 7/27 AM doses Total of 12 missed doses of hydromorphone 4mg. R20's progress notes dated 7/21/26 through 7/27/26, indicated staff noted no supply for each of the 12 missed doses of hydromorphone 4mg as indicted above. pregabalin 100mg 7/24 12:00 p.m. and 8:00 p.m. doses 7/25 8:00 a.m. 12:00 p.m. and 8:00 p.m. doses 7/26 8:00 a.m. 12:00 p.m. and 8:00 p.m. doses 7/27 8:00 a.m. 12:00 p.m. doses Total of 10 missed doses of pregabalin 100mg. R20's progress notes dated 7/24/26 through 7/25/26, indicated staff noted no supply for each of the 10 missed doses of pregabalin 100mg as indicted above. R20's July 2026 MAR indicated R20's pain level was recorded BID on a scale of 1 (no pain) to 10 (worst pain possible). R20's MAR indicated he consistently rated his pain between 6 to 8 during the dates/times R20 received hydromorphone 4mg. However, the facility failed to obtain R20's pain level on the dates/times the facility failed to provide R20's hydromorphone 4mg. Email dated 7/9/26 at 2:26 p.m., from licensed practical nurse (LPN)-C to the provider, indicated the facility requested the provider fax refill orders to the pharmacy for R20's hydromorphone HCL 4mg BID. Email dated 7/22/26 at 10:53 a.m., from licensed practical nurse (LPN)-C to the provider, indicated the facility needed a prescription sent to the pharmacy for (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 0755 Level of Harm - Actual harm Residents Affected - Few	hydromorphone 4mg BID, He is now out of the medication. However, the facility failed to provide evidence that they followed up with the provider for a refill order between 7/9/26 and 7/22/26. Pharmacy reorder form dated 7/24/26, indicated the facility requested a refill of R20's pregabalin 100mg, with special notes listed as no supply. The pharmacy returned the form via fax on 7/24/26, indicated Need new script from new provider. R20's progress note dated 7/26/26 at 11:28 a.m., indicated R20 was not feeling well and lost appetite. R20 had not taken scheduled pregabalin and hydromorphone due to being out of stock/supply and R20 might be going through some withdrawals. R20's progress note dated 7/26/26 at 8:51 p.m., indicated R20 currently out of pregabalin and hydromorphone, and R20 complained of not feeling well, SOB, and skin crawling. The nurse contacted the on-call nurse practitioner to report R20's complaints and need for medication orders. Pharmacy reorder form dated 7/26/26, indicated the facility requested a refill of R20's pregabalin 100mg with special notes listed as out, and hydromorphone 4mg with special notes listed as out. R20's progress note dated 7/27/26 at 2:10 a.m., indicated R20 was administered diphenhydramine (antihistamine) solution 25mg intramuscularly (IM) one time only for Anaphylactic reaction and to contact the MD/NP if repeat dosing needed. R20 observed to exhibit signs and symptoms of withdrawal, including complaints of difficulty sleeping, skin crawling. Pharmacy reorder form dated 7/27/26, indicated the facility requested a refill of R20's pregabalin 100mg with special notes listed as out since 7/24, and hydromorphone 4mg with special notes listed as out since 7/21. R20's progress note, dated 7/28/26 at 5:53 p.m., indicated licensed practical nurse (LPN)-A and the primary care provider (PCP) met with R20, and R20 stated that 'I don't feel good' and resident stated that he thinks he went through some withdrawal. LPN told PCP that R20 had been out of hydromorphone. PCP asked why we stopped his hydromorphone. Writer stated that we did not stop it and that the script [prescription] had not been sent to the pharmacy. R4 R4's quarterly MDS dated [DATE], indicated was cognitively intact, diagnoses included vascular parkinsonism (movement disorder from blocked blood vessels or small strokes), heart failure, and chronic obstructive pulmonary disease (COPD - a long-term lung disease that blocks airflow and makes breathing difficult). R4's care plan revised 4/16/26, indicated R4 was at risk for COPD complications. R4's order summary reviewed 7/30/26, indicated R4 had an order for Ipratropium-Albuterol inhalation solution (Duoneb - used to open lung airways) 0.5-2.5 (3) mg/3mL vial via nebulizer TID related to COPD, with a start date of 6/8/26. R4's July MAR indicated R4 was not administered medications as follows: Ipratropium-Albuterol inhalation solution (Duoneb): 7/9 AM and mid-day (MID) doses 7/10 AM, MID, and HS doses 7/11 AM, MID, and HS doses 7/12 AM, MID, and HS doses 7/13 AM, MID, and HS doses 7/14 AM, MID, and HS doses 7/15 AM, MID, and HS doses 7/16 AM, MID, and HS doses 7/17 AM, MID, and HS doses 7/18 AM, MID, and HS doses 7/19 AM, MID, and HS doses 7/20 AM, MID doses Total of 34 missed Duoneb treatments R4's pharmacy refill authorization form, faxed from the pharmacy to the facility, dated 7/8/26, indicated Please send updated signed med list for R4's Duoneb. Pharmacy reorder form dated 7/8/26, indicated the facility requested a refill of R4s Duoneb with special notes listed as no supply. The pharmacy returned the form via fax on 7/9/26 at 10:38 a.m., indicated Need new signed order. R4's progress notes, dated 7/9/26 through 7/20/26, indicated staff noted no supply for each of the 34 missed Duoneb treatments as indicted above. R4's progress note dated 7/16/26 at 9:10 a.m., indicated R4 requested a PRN (as needed) nebulizer treatment for shortness of breath (SOB). R22 R22's significant change MDS dated [DATE], indicated R22 had moderate cognitive impairment, diagnoses included COPD, spondylosis (causes pain in the spine area that worsens with movement), and chronic pain syndrome, and R22 received scheduled pain medication regimen. R22's care plan revised 7/16/26, indicated R22 preferred comfort-focused treatment. R22's order summary reviewed 7/30/26, indicated R22 had an (continued on next page)		

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F 0755 Level of Harm - Actual harm Residents Affected - Few	order for oxycodone HCL (opioid/narcotic used to treat moderate to severe pain) 5mg by mouth BID related to chronic pain syndrome, with a start date of 6/8/26. R22's July MAR indicated R4 was not administered medications as follows: Oxycodone 5mg:7/18 AM and HS doses7/19 AM and HS doses7/20 AM and HS doses7/21 AM and HS doses7/22 AM doseTotal of 9 missed doses of oxycodone 5mg R22's progress notes dated 7/18/26 through 7/22/26, indicated staff noted no supply for each of the 9 missed doses of oxycodone 5mg. R22's pharmacy refill authorization form, faxed from the pharmacy to the facility, dated 7/8/26, indicated Need new script for R22's oxycodone 5mg by mouth twice a day. R22's pharmacy refill authorization dated 7/15/26, indicated Need New Script for R22's oxycodone 5mg by mouth twice a day. Email dated 7/22/26 at 10:59 a.m., from licensed practical nurse (LPN)-C to the provider, indicated the facility needed a prescription sent to the pharmacy for R22 for oxycodone 5mg BID. During an interview on 7/30/26 at 9:54 a.m., the on-call NP stated when the facility contacted her on 7/26/26, they requested just a refill order. NP stated the nurse failed to notify her R20 had missed several doses of hydromorphone and pregabalin. NP stated the nurse failed to notify her R20 was suffering from any symptoms. NP stated if the nurse had notified her of the missed medications and/or symptoms, NP would have directed the facility to send R20 to emergency room for withdrawal symptoms that possibly could not have been managed at the facility. NP further stated R20 could have suffered additional negative outcomes, such as seizures. During an interview on 7/30/26 at 11:43 a.m., pharmacy consultant (PharmD) stated because R20 had had been on a narcotic consistently and went cold turkey (stopped suddenly), it sounded like R20 suffered withdrawal symptoms due to the medications not being given. PharmD stated R20 had gone a long time without the medication, a provider should have been contacted to provide a prescription, and this was not the goal of care. During an interview on 7/30/26 at 2:20 p.m., director of nursing (DON) confirmed R20 had not received 12 doses of hydromorphone 4mg, and 10 doses of pregabalin 100mg, as per provider orders, and stated, were aware he was out of the medication. DON stated staff should have followed up with the provider between 7/9 and 7/22. DON stated R20 experienced withdrawal symptoms due to the missed medication doses. Additionally, DON stated staff were expected to notify the provider of suspected withdrawal symptoms. DON confirmed R4 had not received 34 Duoneb treatments, and R22 had not received 9 doses of oxycodone 5mg, as per provider orders, due to the facility failure to maintain a supply of the medications. A policy regarding the facility's medication ordering/acquisition process was requested but not provided.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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. Based on observation, interview, and document review, the facility failed to consistently include the facility census on the daily nurse staff posting. This had the potential to affect all 60 current residents, their families and visitorsThe facility's Staffing Data Submission Payroll Based Journal (PBJ), noted the facility was triggered for survey review of Low Weekend Staffing and Licensed Nurses for 24 hours per day during the 1st quarter of 2026 for the following dates:Saturday 10/26/25Saturday 11/29/25Saturday 12/13/25Sunday 12/14/25Sunday 12/28/25 In addition, the facility's Staffing Data Submission Payroll Based Journal (PBJ), noted the facility was triggered for survey review of Licensed Nurses for 24 hours per day during the 2nd quarter of 2026 for the following dates:Saturday 1/3/26Saturday 1/17/26Sunday 1/18/26Saturday 1/24/26Sunday 1/25/26 In review of the facility's staff postings and the actual working schedules for Quarter 1 and Quarter 2 indicated the facility had licensed nursing staff, 24 hours per day, 7 days per week, the review did not identify weekends that were excessively low for staffing. When interviewed on 7/29/26 at 1:30 p.m. staffing coordinator (SC) stated they were only responsible for putting in the information for agency staff. SC stated they were not sure why they would have triggered for anything on the PBJ. When interviewed on 7/29/26 at 1:37 p.m. administrator stated corporate submitted the PBJ. Administrator stated they were not sure that contract/agency staff had been entered for the PBJ. Administrator stated submission of the PBJ was an area for improvement, the triggering on the PBJ was a product of it not being submitted appropriately. Administrator stated there was a high probability that nurse manager hours were not coded correctly when they worked the floor as floor nurses. A facility policy regarding reporting PBJ was requested, however none was provided.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to implement proper infection control procedures when handling soiled linens. This had the potential to affect all residents who used facility laundered linens. Findings include: During observation and interview on 7/29/26 at 1:14 p.m. laundry aide (LA)-F stated the process for laundry services. LA-F stated soiled laundry was sorted by towel, blankets, etc and by unit. LA-F stated they only wear gloves for sorting soiled linens. The gowns hanging in the room were only for COVID. During interview on 7/29/26 at 1:29 p.m. Environmental services director (ES)-G stated his expectation was staff wore gloves and gowns when sorting soiled linens. Facility policy titled: Linen Handling last updated 3/10/26 indicated staff must wear appropriate personal protective equipment based on anticipated exposure and in accordance with standard precautions. Handle all soiled linens a potentially infectious.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and document review, the facility failed to notify the provider of missed medications for 3 of 3 residents (R4, R20, R22) reviewed for medication errors. Additionally, the facility failed to notify the provider of a change in condition for 1 of 1 resident (R20) who exhibited severe withdrawal symptoms. Findings include: R4's quarterly MDS, dated [DATE], indicated was cognitively intact, diagnoses included vascular parkinsonism (movement disorder from blocked blood vessels or small strokes), heart failure, and chronic obstructive pulmonary disease (COPD - a long-term lung disease that blocks airflow and makes breathing difficult). R4's care plan, revised 4/16/26, indicated R4 was at risk for COPD complications. R4's order summary, reviewed 7/30/26, indicated R4 had an order for Ipratropium-Albuterol inhalation solution (Duoneb - used to open lung airways) 0.5-2.5 (3) mg/3mL vial via nebulizer TID related to COPD, with a start date of 6/8/26. R4's July MAR indicated R4 was not administered medications as follows: Ipratropium-Albuterol inhalation solution (Duoneb): 7/9 AM and mid-day (MID) doses 7/10 AM, MID, and HS doses 7/11 AM, MID, and HS doses 7/12 AM, MID, and HS doses 7/13 AM, MID, and HS doses 7/14 AM, MID, and HS doses 7/15 AM, MID, and HS doses 7/16 AM, MID, and HS doses 7/17 AM, MID, and HS doses 7/18 AM, MID, and HS doses 7/19 AM, MID, and HS doses 7/20 AM, MID doses Total of 34 missed Duoneb treatments R4's progress notes, dated 7/9/26 through 7/20/26, indicated staff noted no supply for each of the 34 missed Duoneb treatments as indicted above. R4's progress note, dated 7/16/26 at 9:10 a.m., indicated R4 requested a PRN (as needed) nebulizer treatment for shortness of breath (SOB). However, R4's medical record lacked evidence R4's provider was notified of the 34 missed Duoneb treatments. R20's annual Minimum Data Set (MDS), dated [DATE], indicated R20 was cognitively intact, diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes with diabetic neuropathy (nerve damage in legs and feet), anxiety, and moderate protein-calorie malnutrition, and R20 received scheduled pain medication regimen. R20's care plan, revised 9/10/25, indicated R20 had acute/chronic pain, and interventions included administration of pain medications per order. R20's Order Summary Report, dated 6/3/26, indicated R20 had been taking the following orders long-term: hydromorphone HCL 4 milligrams (mg) by mouth two times a day (BID) related to other chronic pain was ordered 10/27/24 pregabalin 100mg by mouth three times a day (TID) for chronic pain was ordered 6/25/25 R20's July 2026 Medication Administration Record (MAR) indicated R20 was not administered medications as follows: hydromorphone 4mg 7/21 bedtime (HS) dose 7/22 morning (AM) and HS doses 7/23 AM and HS doses 7/24 AM and HS doses 7/25 AM and HS doses 7/26 AM and HS doses 7/27 AM doses Total of 12 missed doses of hydromorphone 4mg R20's progress notes, dated 7/21/26 through 7/27/26, indicated staff noted no supply for each of the 12 missed doses of hydromorphone 4mg as indicted above. pregabalin 100mg 7/24 12:00 p.m. and 8:00 p.m. doses 7/25 8:00 a.m. 12:00 p.m. and 8:00 p.m. doses 7/26 8:00 a.m. 12:00 p.m. and 8:00 p.m. doses 7/25 8:00 a.m. 12:00 p.m. doses Total of 10 missed doses of pregabalin 100mg R20's progress notes, dated 7/24/26 through 7/25/26, indicated staff noted no supply for each of the 10 missed doses of pregabalin 100mg as indicted above. However, R20's medical record lacked evidence R20's provider was notified of the 12 missed doses of hydromorphone 4mg and/or the 10 missed doses of pregabalin 100mg. R20's progress note, dated 7/26/26 at 11:28 a.m., indicated R20 was not feeling well and lost appetite. R20 had not taken scheduled pregabalin and hydromorphone, due to being out of stock/supply and R20 might be going through some withdrawals. R20's progress note, dated 7/26/26 at 8:51 p.m., indicated (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R20 currently out of pregabalin and hydromorphone, and R20 complained of not feeling well, SOB, and skin crawling. The nurse contacted the on-call nurse practitioner to report R20's complaints and need for medication orders. R20's progress note, dated 7/27/26 at 2:10 a.m., indicated R20 was administered diphenhydramine (antihistamine) solution 25mg intramuscularly (IM) one time only for Anaphylactic reaction and to contact the MD/NP if repeat dosing needed. R20 observed to exhibit signs and symptoms of withdrawal, including complaints of difficulty sleeping, skin crawling. However, R20's medical record lacked evidence R20's provider was notified of R20's change in condition. R20's progress note, dated 7/28/26 at 5:53 p.m., indicated licensed practical nurse (LPN)-A and the primary care provider (PCP) met with R20, and R20 stated that 'I don't feel good' and resident stated that he thinks he went through some withdrawal. LPN told PCP that R20 had been out of hydromorphone. PCP asked why we stopped his hydromorphone. Writer stated that we did not stop it and that the script [prescription] had not been sent to the pharmacy. During an interview on 7/29/26 at 2:35 p.m., R20 stated he went without his hydromorphone and pregabalin for days and went into withdrawal. R20 stated he was shaking, short of breath (SOB), sweating, nauseous, heart racing, and was in horrible pain. R20 stated he didn't eat for two days, wanted to crawl out of my own skin and it was a miserable four days. R22's significant change MDS, dated [DATE], indicated R22 had moderate cognitive impairment, diagnoses included COPD, spondylosis (causes pain in the spine area that worsens with movement), and chronic pain syndrome, and R22 received scheduled pain medication regimen. R22's care plan, revised 7/16/26, indicated R22 preferred comfort-focused treatment. R22's order summary, reviewed 7/30/26, indicated R22 had an order for oxycodone HCL (opioid/narcotic used to treat moderate to severe pain) 5mg by mouth BID related to chronic pain syndrome, with a start date of 6/8/26. R22's July MAR indicated R4 was not administered medications as follows: Oxycodone 5mg: 7/18 AM and HS doses 7/19 AM and HS doses 7/20 AM and HS doses 7/21 AM and HS doses 7/22 AM dose Total of 9 missed doses of oxycodone 5mg R22's progress notes, dated 7/18/26 through 7/22/26, indicated staff noted no supply for each of the 9 missed doses of oxycodone 5mg. However, R22's medical record lacked evidence R22's provider was notified of the 9 missed doses of oxycodone 5mg. During an interview on 7/30/26 at 9:54 a.m., the on-call NP stated when the facility contacted her on 7/26/26, they requested just a refill order for R20's medications. NP stated the nurse failed to notify her R20 had missed several doses of hydromorphone and pregabalin, and that R20 suffered from any symptoms. NP stated had the nurse notified her of the missed medications and/or symptoms, NP would have directed the nurse to send R20 to emergency room for withdrawal symptoms that possibly could not have been managed at the facility. NP further stated the nurse needed to provide a thorough SBAR (situation-background-assessment-recommendation) about the current situation and background. During an interview on 7/30/26 at 2:20 p.m., director of nursing (DON) stated it was important to keep the provider updated, and the nurses were expected to notify the provider in SBAR form for any missed medications and/or change in condition. The facility's Change in Condition policy, revised 7/29/25, indicated the facility would inform the resident, consult with the physician, and notify the resident representative when a change occurred, to ensure timely identification, assessment, and intervention for significant changes in resident's condition.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure meal trays were served in a timely manner for 6 of 6 resident trays sampled to preserve desired temperatures and palatability. This had the potential to affect all residents who chose to eat on the unit or in their rooms. Findings include: During survey entrance on 7/26/26 at 8:30 a.m., facility mealtimes were requested and provided by facility Administrator (Admin) via email. The provided times were as follows: Breakfast - 8 AMLunch - NoonSupper - 5 PMEvening - snacks are offered and always available During observation and interview on 7/27/26 at 5:28 p.m., the following temperatures were recorded by the Dietary Manager (DM) on a resident meal tray: Chicken - 105 degreesPotato - 108 degreesSliced Carrots - 94Jello - 53 degreesCranberry juice - 60 degreesIce water - 52 degreesDM stated meals served on the pod are dished in the dining room before residents are allowed into the dining room. DM stated staff on each pod is alerted via walkie talkies when trays are being delivered to the pods and then staff in the pod deliver the trays to the residents. DM stated dietary staff was responsible to deliver trays to the [NAME] pod and floor staff on Maple was responsible for delivering those trays. During observation of noon meal tray delivery on 7/28/26 at 12:11 p.m., certified nursing assistant (CNA-A) checked meals trays delivered to Maple pod with a digital food thermometer. The following was observed: Room tray for room [ROOM NUMBER] - both cold and hot food was under a plastic cover and served on the same plateShredded beef - 121.6 degreesTater Tots - 98.4 degreesSalad - 67.5 degreesStrawberries with whipped topping - 64.2 degreesApple juice - 54.7 degrees Room tray for room [ROOM NUMBER]Shredded beef on bun - 118.2 degreesGreen beans - 104.5 degreesStrawberries with whipped topping - 64.6 degreesApple juice 52.9 degrees CNA-A was unable to state what the safe and desirable temperature of each food should be. CNA-A stated she had not ever thought about the temp and 'just delivered trays' to the residents. During interview on 7/28/26 at 1:17 p.m. DM stated food served outside of the safe zone increases the risk of food born illnesses. When reviewing the temps taken on 7/26/26, DM stated she would not want to eat cold chicken or drink warm milk. DM stated she expected staff to deliver meal trays to residents as soon as they were delivered to the pod and to warm up trays of cold food or offer the resident a fresh tray. DM was unable to state how long meal trays sat on each pod before staff delivered them. On 7/29/26 at 9:41 a.m., a large, uncovered cart was observed sitting in the pod of residents' rooms waiting to be delivered. Plates were covered and sitting on trays, they were not enclosed in a cart, or on warmer plates. ON 7/29/26 at 9:41 a.m., a nursing assistant (NA)-B working on the unit confirmed the trays were waiting to be delivered and had been dropped off about 20 mins prior. While speaking to NA-B they took a tray from the cart and went and warmed it up in the microwave on the unit. NA-B stated although she reheated the plate, she did not temp the food nor was aware she should. On 7/29/26 at approximately 9:50 a.m., dietary manager (DM) was asked to come to the floor with a thermometer and the following temperatures on two trays of resident food were observed: Tray #1 labeled room [ROOM NUMBER]: Eggs-87 degrees Fahrenheit (°F) Toast-82 °FBacon-78 °FCoffee-114 °FMilk-58 °F Tray #2 labeled room [ROOM NUMBER]: Pancakes-92 °FSausage-93 °FBacon-86 °FStrawberries-70 °F The DM stated these temperatures did not meet their expectations, and they expected staff to warm and recheck the temperatures of food prior to serving it to the residents. The DM removed the trays and had the residents provided with a new meal. On 7/29/26 at 10:00 a.m. the administrator and the DM stated they were unsure if the floor staff have been trained on when or to what temperature the food should be at prior to being served. The administrator and DM confirmed the food should have (continued on next page)		

Department of Health & Human Services
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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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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been warmed prior to being given to the residents and the above listed temperatures were outside of their expectations.A policy related to food temperatures was requested and none were provided.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a comprehensive care plan was developed and/or maintained to ensure proper goals and interventions were in place to maintain adequate nutritional status for 1 of 1 resident (R4) reviewed for care plans. Findings include: R4's quarterly Minimum Data Set (MDS) indicated R4's most recent admission to the facility was 4/10/26, cognitively intact, and had the following diagnoses: Heart failure, Chronic Obstructive Pulmonary Disease and Dysphagia (trouble swallowing involving both the mouth and throat parts of swallowing food/fluids). During initial record review on 8/26/26 at 11:33 a.m., indicated R4's most current weight as 168.6 lbs. The record further indicated R4 had a 14.33% weight loss over 6 months. Nutritional risk assessment completed 6/8/26 indicated R4's weight on 6/2/26 was 173lbs. The assessment further indicated R4's goal weight was 172-185, his oral intake was 51-75% of meals served and listed soft and bite sized with mildly thickened liquids as current ordered diet. Dietary assessment completed 6/8/26, indicated R4 did not have a swallowing disorder and was not on a prescribed weight-loss regimen. R4's care plan reviewed 8/28/26, indicated a focus of potential for altered nutrition, listed a goal of maintaining weight to within 5% of admission weight, and listed the goal weight range as 200-220lbs. During interview on 7/29/26 at 2:02 p.m., Licensed Practical Nurse manager (LPN-A) for the Maple unit stated he was familiar with R4 and his care plan. LPN-A stated he was aware of R4's diagnosis of dysphagia and stated he was on an altered diet of soft and bite sized pieces. LPN-A stated care plans were collaborative and included input from nursing and dietary staff. During interview on 7/29/26 at 4:24 p.m., Director of Nursing (DON) stated she was aware of R4 and his current health issues. DON stated care plans were completed primarily by the unit managers but were discussed with all team members to provide a whole picture of the residents. DON confirmed R4's care plan lacked accurate current information and had not been updated to reflect his current nutritional status and weight goals. DON stated she expected care plans to be reviewed routinely for accuracy and update accordingly. DON stated it was important for the care plans to be current and updated with accurate information to address their individual health needs. Facility policy titled Person Centered Care Planning indicated St [NAME] Health Services will develop and implement a person-centered care plan with identified medical, nursing, mental and psychosocial needs. The policy out lined the care plan will include measurable goals and interventions, identifying services to maintain or improve highest practicable well-being. It also indicated the care plan will be reviewed and revised quarterly, upon significant change of condition, or as otherwise necessary to reflect the residents' current needs, goals and preferences.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to monitor weights and modify/develop specific interventions for 1 of 1 resident reviewed for significant, unintentional weight loss. Findings include: R4's quarterly minimum data set (MDS) dated [DATE], indicted R4 admitted to the facility on [DATE], was cognitively intact and had the following diagnoses: Chronic Obstructive Pulmonary Disease, Heart failure, Dysphagia and Parkinsonism. R4's Nutritional Risk assessment dated [DATE] indicated R4's current weight as 173 lbs., indicated a 4% weight loss over 30 days, 10.3% weight loss over 180 days and indicated R4's goal weight as 172-185lbs. The assessment lacked recognizing R4's diagnosis of dysphagia and failed to identify R4's estimated nutritional needs. R4's Dietary assessment dated [DATE], indicated R4 was not on a prescribed weight-loss regimen and received a mechanically altered diet. R4's orders reviewed on 7/28/26 indicated R4 was to be weighed weekly and received a soft and bite size texture diet with nectar thick liquids. The orders lacked any order for dietary supplements to reduce weight loss. A progress note dated 6/8/26 indicated R4 had no decrease in food intake over previous 3 months, had weight loss greater than 3kg(6.6lbs) in previous 3 months, and had a mini nutrition score of 11 indicating at risk for malnutrition. Progress/dietary note dated 6/8/26 indicated weights: 173 (current); 180 (30d: 4% loss); 193 (180d: 10.3% loss) and indicated R4 required assistance with meals due to occasional swallowing difficulty. R4's care plan indicated a focus of potential for alteration in nutrition due to leaving 25% or more food uneaten at meals indicated goals of maintaining weight to within 5% of admitted weight and having adequate nutritional intake. Interventions included encouragement to feed self (initiated 11/4/24), fortified foods (initiated 5/6/26), monitor weights weekly (initiated 11/4/24) and offer substitutes for dislikes when not eating (initiated 11/4/24). The care plan lacked any evidence of including a dietary supplement to R4's diet to maintain weight. Review of R4's weights from 2/17/26 through 7/28/26 revealed the following documented weights indicating a 14.33% weight loss over the previous 6 months: 7/28/2026 165.0 7/25/2026 168.6 7/21/2026 167.6 7/14/2026 169.5 7/7/2026 170.6 6/30/2026 169.4 6/23/2026 172.0 6/13/2026 176.0 6/9/2026 176.8 6/2/2026 173.0 5/30/2026 177.0 5/26/2026 177.0 5/23/2026 175.0 5/19/2026 179.2 5/12/2026 180.3 5/5/2026 179.8 4/28/2026 179.8 3/31/2026 182.6 3/24/2026 185.03/17/2026 184.2 3/17/2026 186.0 3/10/2026 183.6 3/3/2026 192.2 2/24/2026 187.8 2/17/2026 192.6 During interview on 7/29/26 at 2:02 p.m., Licensed Practical Nurse (LPN-A) stated R4 fluctuated between partial to full assistance with meals, did not refuse meals and had dysphagia. LPN-A confirmed R4 had steadily lost weight since his recorded weight on 2/17/26. LPN-A stated the facility registered dietician was aware but could not confirm if R4's primary care physician was aware of the weight loss. During interview on 7/29/26, at 4:24 p.m., Director of Nursing (DON) stated R4 could feed himself, took his meals in the dining room and did not refuse meals. DON stated R4 had a swallowing disorder and Parkinsonism which would 'complicate' swallowing. DON confirmed that R4 had lost greater than 14% over the previous 6 months and agreed that was a significant weight loss. DON stated her expectation for monitoring weights is any weight loss of 5% in one month and/or 10% in 6 months the primary physician should be updated. DON stated it was important to monitor weights and update the provider of continued unplanned weight loss and failure to identify or stabilize an unplanned weight loss could negatively affect a resident by muscle loss, weakness and general deconditioning. During phone interview on 7/29/26, at 5:15 p.m., Registered Dietician (RD) stated she was familiar with R4 and was aware there was some weight discrepancies. RD stated R4 had a fortified diet put in place on 7/13/26 but continued to lose (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight. RD stated R4 should also been receiving a dietary supplement such as Ensure or Boost, however, could not identify why she had not made that recommendation to the care team. Facility policy title Weight Monitoring Program with a last review date of 1/18/21 indicated the facility will monitor weights of individuals receiving services to prevent unintended weight loss and medically significant weight gain. The policy indicated a significant weight loss of 5% or more in 30 days or 10% or more within 180 days. The policy identified dysphagia as difficulty swallowing and can result from a lack of saliva, weak chewing muscles, lack of tongue control, absent or delayed reflexes, muscle paralysis, and/or a lack of proper coordination with breathing. The policy further indicated the following actions and interventions: IRS will be weighed weekly, as needed, or as ordered by physician/attending practitioner; Interdisciplinary team (IDT) will discuss the IRS with at risk weight loss, significant weight loss, or medically significant weight gain weekly. Documentation will include determined interventions; Dietary Risk and Nutritional Risk Assessments will be completed upon admission, annually, quarterly or with a significant change in condition; care plan will be initiated/updated based upon assessments; Assess and identify nutritional problems, eating and drinking habits, activity level, and patterns; Fortify foods and beverages to increase calories and offer high calorie foods/beverages during meals and snacks; Offer high calorie foods and beverages throughout the day and have readily available in room (if allowed and no choking risks); Supplements such as a high calorie shake, Ensure, Boost, etc. may be added as needed; these are best given between breakfast and lunch, between lunch and supper, or between supper and bedtime; supplements should not be given at mealtime unless preferred by resident or family designee or if ordered by physician; Medication review with pharmacist/pharmacy consultant will occur to identify any appetite suppressers; Consultation with physician/attending practitioner to determine if IRS could benefit from an appetite stimulant; Ensure documentation of all interventions tried to improve calorie and nutritional intake to prevent unintended. Refusals of meals, snacks, and alternate choices offered along with IRS' response should be documented; Assess and adjust care plans to meet the IRS' medical, physical, mental, and psychosocial needs in a way that supports overall nutrition; Audit and review nutrition progress notes and documentation regularly; any concerns or trends identified will be discussed at IDT; Quality Assurance Performance Improvement (QAPI) team will review at risk weight loss, significant weight loss, and medically significant weight gain data at meetings.		

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F 0572 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. Based on observation, interview, and record review, the facility failed to ensure residents were promptly informed of changes to the Nursing Home Resident [NAME] of Rights (RBOR) and failed to ensure the current RBOR was available and displayed for residents, staff, and visitors to review. This deficient practice had the potential to affect 60 residents, as well as staff and visitors who relied on the outdated information. Findings include: On 7/30/26 at 2:25 p.m., an outdated RBOR was observed posted in the facility. On 7/30/26 at 2:25 p.m., social services director (SSD) confirmed the posted RBOR information was outdated. SSD stated it was their responsibility to hang and keep the information updated, and it had not been completed. A policy regarding posting the RBOR was requested and none was provided.		