DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 18, 2026

Administrator
LITTLE FALLS CARE CENTER
1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

RE: CCN: 245399
Cycle Start Date: July 30, 2026

Dear Administrator:

On July 30, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 2, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 2, 2026. They will also notify the State

Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 2, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 2, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, [Facility Name()] will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 2, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Deborah Willis, Regional Operations Supervisor
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Deborah.Willis@state.mn.us
Office: (651) 201-3793

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

A Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 30, 2027 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP.

This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

An equal opportunity employer.

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Administrator
LITTLE FALLS CARE CENTER
1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

Re: State Nursing Home Licensing Orders
Event ID: 235D4C-H1

Dear Administrator:

The above facility survey was completed on July 30, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Deborah Willis, Regional Operations Supervisor
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Deborah.Willis@state.mn.us
Office: (651) 201-3793

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On (7/26/26 through 7/30/26), a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: NO	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/30/2026**

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20000	Continued from page 1 deficiencies were cited. H53993427C/IQIES#: 3044439 H553993428C/IQIES#: 3041144 H53993434C/IQIES#: 2654380 H53993434C/IQIES#: 2653519 H53993426C/IQIES#: 3068268 H539923429C/IQIES#: 2998972 H53993433C/IQIES#: 2802683 H53993430C/IQIES#: 2798531 H53993431C/IQIES#: 2797371 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	20000		

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20000	Continued from page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	20265		

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20265	Continued from page 3 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 6/15/26, 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	20265		

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20265	Continued from page 4 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 3/16/26, 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 pregablin 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	20265		

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20265	Continued from page 5 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 R20 currently out of pregabalin and hydromorphone, and R20 complained of “not feeling well”, SOB, and “skin crawling”. The nurse	20265		

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20265	Continued from page 6 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 6/2/26, 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	20265		

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20265	Continued from page 7 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-recommendatio n) 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 (situation, background, action, recommendation) form for any missed medications and/or change in condition.	20265		

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20265	Continued from page 8 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	20555		

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20555	Continued from page 9 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 Francis 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	20555		

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20555	Continued from page 10 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		
20965	Dietary Service -Nutritional Status CFR(s): MN Rule 4658.0600 Subp. 2 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 6/15/26, indicted R4 admitted to the facility on 9/26/23, was cognitively intact and had the following diagnoses: Chronic Obstructive Pulmonary Disease, Heart failure, Dysphagia and Parkinsonism. R4's Nutritional Risk assessment dated 6/8/26 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 6/8/26, indicated R4 was not on a prescribed weight-loss regimen and received a mechanically altered diet.	20965		

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20965	Continued from page 11 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 (initiated11/4/24). 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	20965		

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20965	Continued from page 12 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 185.0 3/17/2026 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	20965		

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20965	Continued from page 13 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 weight. RD stated R4 should lso 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	20965		

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20965	Continued from page 14 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20965		
21025	Food Temperatures CFR(s): MN Rule 4658.0615 Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	21025		

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21025	Continued from page 15 times were as follows: Breakfast - 8 AM Lunch - Noon Supper - 5 PM Evening - 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 degrees Potato - 108 degrees Sliced Carrots - 94 Jello - 53 degrees Cranberry juice - 60 degrees Ice water - 52 degrees DM 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 Lindberg 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 116 - both cold and hot food was under a plastic cover and served on the same plate Shredded beef - 121.6 degrees Tater Tots - 98.4 degrees Salad - 67.5 degrees Strawberries with whipped topping - 64.2 degrees	21025		

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21025	Continued from page 16 Apple juice - 54.7 degrees Room tray for room 120 Shredded beef on bun - 118.2 degrees Green beans - 104.5 degrees Strawberries with whipped topping - 64.6 degrees Apple 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 316: Eggs-87 degrees Fahrenheit (˚F)	21025		

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21025	Continued from page 17 Toast-82 ˚F Bacon-78 ˚F Coffee-114 ˚F Milk-58 ˚F Tray #2 labeled Room 303: Pancakes-92 ˚F Sausage-93 ˚F Bacon-86 ˚F Strawberries-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 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated on proper use of thermometers, and that they are made available, to ensure food is at the appropriate temperature prior to serving. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing	21375		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
21375	Continued from page 18 home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated on handling soiled linens. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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.	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345**

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21550	Continued from page 19 Findings include: R20 R20’s annual Minimum Data Set (MDS), dated 3/16/26, 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 pregablin 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	21550		

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21550	Continued from page 20 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. 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 hydromorphone 4mg BID, “He is now out of the	21550		

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21550	Continued from page 21 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.,	21550		

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21550	Continued from page 22 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 6/15/26, 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	21550		

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21550	Continued from page 23 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 6/2/26, 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.	21550		

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21550	Continued from page 24 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. 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.	21550		

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21550	Continued from page 25 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21800	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute144.651 Subd. 4 Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01,	21800		

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21800	Continued from page 26 the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were promptly informed of changes to the Nursing Home Resident Bill 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure poster is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026

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E0000	Initial Comments On 7/26/26 through 7/30/26, a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E0000		
F0000	INITIAL COMMENTS On 7/26/26 through 7/30/26, a standard recertification survey (S5459041) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: NO deficiencies were cited. H53993427C/IQIES#: 3044439 H553993428C/IQIES#: 3041144 H53993434C/IQIES#: 2654380 H53993434C/IQIES#: 2653519 H53993426C/IQIES#: 3068268 H539923429C/IQIES#: 2998972 H53993433C/IQIES#: 2802683	F0000		

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 reverse for further 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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F0000	Continued from page 1 H53993430C/IQIES#: 2798531 H53993431C/IQIES#: 2797371 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0755 SS = G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F0755		

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F0755 SS = G	Continued from page 2 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: 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 3/16/26, 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 pregablin 100mg by mouth three times a day (TID) for chronic pain was ordered 6/25/25	F0755		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345

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F0755 SS = G	Continued from page 3 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. 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	F0755		

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F0755 SS = G	Continued from page 4 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 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)	F0755		

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F0755 SS = G	Continued from page 5 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 6/15/26, 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	F0755		

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F0755 SS = G	Continued from page 6 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 6/2/26, indicated R22 had moderate cognitive impairment, diagnoses included COPD, spondylosis (causes pain	F0755		

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F0755 SS = G	Continued from page 7 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. 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.	F0755		

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F0755 SS = G	Continued from page 8 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.	F0755		
E0007 SS = F	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3),	E0007		

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E0007 SS = F	Continued from page 9 §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the emergency preparedness plan included their vulnerable patient population including persons at-risk and the type of services required to meet their needs. This had the potential to affect all residents residing in the facility. Findings include: The facility's emergency preparedness (EP) plan was reviewed and lacked collaboration with their facility assessment to include the patient population served within the facility and their unique vulnerabilities in the event of an emergency or disaster. During interview on 7/30/26 at 8:15 a.m. Administrator stated they did not have the patient population calculated or included in their EP plan. A facility policy was request but none provided.	E0007		

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E0036 SS = F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must	E0036		

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E0036 SS = F	Continued from page 11 develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interviews, the facility failed to develop and maintain an emergency preparedness (EP) training and testing program which was based on the emergency plan, risk assessment, policies and procedures. This had the potential to affect all residents residing at the facility. Findings include: During review of the facility's EPP, it was revealed the EP program lacked evidence of a required full-scale community-based, or a tabletop exercise since January 2025. On 5/22/26 at 3:49p.m., the administrator stated no exercises have been completed within the past year. A policy was requested, however, none provided.	E0036		
E0037 SS = F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff,	E0037		

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E0037 SS = F	Continued from page 12 individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E0037		

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E0037 SS = F	Continued from page 13 (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency	E0037		

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E0037 SS = F	Continued from page 14 procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E0037		

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E0037 SS = F	Continued from page 15 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interviews, the facility failed to develop and maintain emergency preparedness plan (EPP) training program which was based on the emergency plan, risk assessment, policies, and procedures. This had the potential to affect all residents residing at the facility and staff members. Findings include: During review of the facility's initial EP program training, nursing assistant (NA)-C lacked evidence initial EP training was completed upon hire. Further, licensed practical nurse (LPN)-A lacked evidence of EP annual training. On 7/31/26 at 10:00 a.m. business office manager stated there was no evidence NA-C completed the initial EP training. Further, there was no annual EP training found for LPN-A A policy related to EPP was requested, and none was provided.	E0037		
E0039 SS = F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to	E0039		

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E0039 SS = F	Continued from page 16 test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or	E0039		

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E0039 SS = F	Continued from page 17 (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or	E0039		

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E0039 SS = F	Continued from page 18 (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.	E0039		

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E0039 SS = F	Continued from page 19 *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:	E0039		

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E0039 SS = F	Continued from page 20 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the	E0039		

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E0039 SS = F	Continued from page 21 emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E0039		

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E0039 SS = F	Continued from page 22 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.	E0039		

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E0039 SS = F	Continued from page 23 This REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the facility failed to develop and maintain an emergency preparedness plan (EPP) training and testing program which wa based on the emergency plan, risk assessment, policies and procedures. This had the potential to affect all residents residing at the facility. Findings include: During review of the facility's EPP, the facility last performed an exercise in January 2025. During interview on 7/30/26 at 8:15 a.m. Administrator stated they had not completed any exercises since January 2025. A policy was requested, however, none provided.	E0039		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical	F0851		

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F0851 SS = F	Continued from page 24 nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: 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 visitors The 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 10/26/25 Saturday 11/29/25 Saturday 12/13/25 Sunday 12/14/25 Sunday 12/28/25	F0851		

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F0851 SS = F	Continued from page 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 1/3/26 Saturday 1/17/26 Sunday 1/18/26 Saturday 1/24/26 Sunday 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.	F0851		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection	F0880		

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F0880 SS = F	Continued from page 26 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by	F0880		

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F0880 SS = F	Continued from page 27 staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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.	F0880		
F0580 SS = E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F0580		

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F0580 SS = E	Continued from page 28 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: 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	F0580		

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F0580 SS = E	Continued from page 29 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 6/15/26, 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	F0580		

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F0580 SS = E	Continued from page 30 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 3/16/26, 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 pregablin 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	F0580		

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F0580 SS = E	Continued from page 31 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 R20 currently out of pregabalin and hydromorphone, and R20 complained of "not feeling	F0580		

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F0580 SS = E	Continued from page 32 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 6/2/26, 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	F0580		

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F0580 SS = E	Continued from page 33 (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-recommendatio n) 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.	F0580		

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F0580 SS = E	Continued from page 34 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.	F0580		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: 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 AM Lunch - Noon Supper - 5 PM Evening - 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 degrees	F0804		

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F0804 SS = E	Continued from page 35 Potato - 108 degrees Sliced Carrots - 94 Jello - 53 degrees Cranberry juice - 60 degrees Ice water - 52 degrees DM 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 Lindberg 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 116 - both cold and hot food was under a plastic cover and served on the same plate Shredded beef - 121.6 degrees Tater Tots - 98.4 degrees Salad - 67.5 degrees Strawberries with whipped topping - 64.2 degrees Apple juice - 54.7 degrees Room tray for room 120 Shredded beef on bun - 118.2 degrees Green beans - 104.5 degrees Strawberries with whipped topping - 64.6 degrees Apple juice 52.9 degrees CNA-A was unable to state what the safe and desirable temperature of each food should be.	F0804		

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F0804 SS = E	Continued from page 36 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 316: Eggs-87 degrees Fahrenheit (˚F) Toast-82 ˚F Bacon-78 ˚F Coffee-114 ˚F Milk-58 ˚F Tray #2 labeled Room 303: Pancakes-92 ˚F Sausage-93 ˚F	F0804		

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F0804 SS = E	Continued from page 37 Bacon-86 ˚F Strawberries-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 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.	F0804		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0656 SS = D	Continued from page 38 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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.	F0656		

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F0656 SS = D	Continued from page 39 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 Francis 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.	F0656		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F0692		

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F0692 SS = D	Continued from page 40 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: 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 6/15/26, indicted R4 admitted to the facility on 9/26/23, was cognitively intact and had the following diagnoses: Chronic Obstructive Pulmonary Disease, Heart failure, Dysphagia and Parkinsonism. R4's Nutritional Risk assessment dated 6/8/26 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 6/8/26, 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	F0692		

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F0692 SS = D	Continued from page 41 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 (initiated11/4/24). 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	F0692		

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F0692 SS = D	Continued from page 42 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 185.0 3/17/2026 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.	F0692		

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F0692 SS = D	Continued from page 43 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 weight. RD stated R4 should lso 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	F0692		

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F0692 SS = D	Continued from page 44 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.	F0692		
E0030 SS = C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E0030		

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E0030 SS = C	Continued from page 45 (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following:	E0030		

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E0030 SS = C	Continued from page 46 (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is NOT MET as evidenced by: Base on interview and document review the facility failed to ensure the emergency preparedness plan (EPP) included a current listing of names and contact information. This had the potential to affect all residents residing in the facility. Findings included: The facility's EPP was reviewed and included a list of contact information; however, key current staff were not listed. During interview on 7/30/26 at 8:15 a.m. Administrator stated the contact information included was outdated and he had updated the list. A policy was requested; however, none was provided.	E0030		
E0034 SS = C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that	E0034		

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E0034 SS = C	Continued from page 47 complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan (EPP) included a means for providing information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee. Findings inclued: A review of the facility EPP lacked evidence the communication plan had a procedure to provide information regarding the facility's occupancy, needs, and ability to provide assistance to outside sources, such as the authority having jurisdiction over the facility, the incident command center or other designee. During interview on 7/30/26 at 8:15 a.m. Administrator stated he had not share occupancy in years. This was not included in the EPP. A policy was requested; however, none was provided.	E0034		
F0572 SS = C	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication.	F0572		

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F0572 SS = C	Continued from page 48 §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were promptly informed of changes to the Nursing Home Resident Bill 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.	F0572		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On (7/26/26 through 7/30/26), a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: NO	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/30/2026**

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20000	Continued from page 1 deficiencies were cited. H53993427C/IQIES#: 3044439 H553993428C/IQIES#: 3041144 H53993434C/IQIES#: 2654380 H53993434C/IQIES#: 2653519 H53993426C/IQIES#: 3068268 H539923429C/IQIES#: 2998972 H53993433C/IQIES#: 2802683 H53993430C/IQIES#: 2798531 H53993431C/IQIES#: 2797371 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	20000		

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20000	Continued from page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	20265		

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20265	Continued from page 3 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 6/15/26, 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	20265		

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20265	Continued from page 4 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 3/16/26, 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 pregablin 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	20265		

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20265	Continued from page 5 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 R20 currently out of pregabalin and hydromorphone, and R20 complained of “not feeling well”, SOB, and “skin crawling”. The nurse	20265		

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20265	Continued from page 6 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 6/2/26, 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	20265		

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20265	Continued from page 7 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-recommendatio n) 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 (situation, background, action, recommendation) form for any missed medications and/or change in condition.	20265		

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20265	Continued from page 8 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	20555		

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20555	Continued from page 9 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 Francis 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	20555		

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20555	Continued from page 10 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		
20965	Dietary Service -Nutritional Status CFR(s): MN Rule 4658.0600 Subp. 2 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 6/15/26, indicted R4 admitted to the facility on 9/26/23, was cognitively intact and had the following diagnoses: Chronic Obstructive Pulmonary Disease, Heart failure, Dysphagia and Parkinsonism. R4's Nutritional Risk assessment dated 6/8/26 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 6/8/26, indicated R4 was not on a prescribed weight-loss regimen and received a mechanically altered diet.	20965		

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20965	Continued from page 11 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 (initiated11/4/24). 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	20965		

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20965	Continued from page 12 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 185.0 3/17/2026 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	20965		

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20965	Continued from page 13 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 weight. RD stated R4 should lso 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	20965		

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20965	Continued from page 14 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20965		
21025	Food Temperatures CFR(s): MN Rule 4658.0615 Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	21025		

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21025	Continued from page 15 times were as follows: Breakfast - 8 AM Lunch - Noon Supper - 5 PM Evening - 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 degrees Potato - 108 degrees Sliced Carrots - 94 Jello - 53 degrees Cranberry juice - 60 degrees Ice water - 52 degrees DM 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 Lindberg 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 116 - both cold and hot food was under a plastic cover and served on the same plate Shredded beef - 121.6 degrees Tater Tots - 98.4 degrees Salad - 67.5 degrees Strawberries with whipped topping - 64.2 degrees	21025		

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21025	Continued from page 16 Apple juice - 54.7 degrees Room tray for room 120 Shredded beef on bun - 118.2 degrees Green beans - 104.5 degrees Strawberries with whipped topping - 64.6 degrees Apple 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 316: Eggs-87 degrees Fahrenheit (˚F)	21025		

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21025	Continued from page 17 Toast-82 ˚F Bacon-78 ˚F Coffee-114 ˚F Milk-58 ˚F Tray #2 labeled Room 303: Pancakes-92 ˚F Sausage-93 ˚F Bacon-86 ˚F Strawberries-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 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated on proper use of thermometers, and that they are made available, to ensure food is at the appropriate temperature prior to serving. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing	21375		

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21375	Continued from page 18 home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated on handling soiled linens. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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.	21550		

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21550	Continued from page 19 Findings include: R20 R20’s annual Minimum Data Set (MDS), dated 3/16/26, 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 pregablin 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	21550		

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21550	Continued from page 20 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. 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 hydromorphone 4mg BID, “He is now out of the	21550		

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21550	Continued from page 21 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.,	21550		

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21550	Continued from page 22 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 6/15/26, 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	21550		

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21550	Continued from page 23 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 6/2/26, 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.	21550		

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21550	Continued from page 24 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. 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.	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345**

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21550	Continued from page 25 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21800	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute144.651 Subd. 4 Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01,	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/30/2026**

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21800	Continued from page 26 the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were promptly informed of changes to the Nursing Home Resident Bill 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure poster is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING **03 - EAST BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 03	INITIAL COMMENTS An annual Life Safety survey was conducted on 07/27/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Little Falls Care Center, Building 03 - East Building Addition was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE	K0000		08/31/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - EAST BUILD... B. WING	(X3) DATE SURVEY COMPLETED 07/27/2026

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K0000 Bldg. 03	Continued from page 1 FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was inspected as two buildings: Little Falls Care Center consists of two buildings separated by a 2 hour fire separation. Building 03, the East Building Addition is 1 story buildings without a basement built in 2016 and was determined to be Type II(111) construction. Building 04, the West building is a 1 story building without a basement and was determined to be Type II(111) construction. Since Building 03 was built under the 2000 edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code and Building 04 was built to the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code the two buildings were inspected separately. The facility is fully protected with an automatic sprinkler system and also has a fire alarm system which includes corridor smoke detection throughout and in all common areas. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 60 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K0000		08/31/2026
K0921 SS = F Bldg. 03	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are	K0921	The facility completed an inventory of electric beds and patient-care-related electrical equipment (PCREE), including nebulizers, oxygen concentrators, portable suction units, and other applicable electrical medical equipment. Equipment was reviewed to verify required inspection and maintenance was completed and documented. The Environmental Services Director/designee will maintain a current inventory and preventive maintenance schedule for electric beds and PCREE	08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING **03 - EAST BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/27/2026**

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K0921 SS = F Bldg. 03	Continued from page 2 established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities Code 2012 Edition, section 10.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/27/2026 at 10:34 AM, it was revealed that the facility failed to provide documentation on the electric beds for all residents, and that PCREE such as nebulizers, oxygen concentrators, portable suction units, and other electrical medical equipment was present at the facility was inspected and maintained. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0921	Continued from page 2 and ensure required inspections, maintenance, and documentation are completed. Environmental Services staff responsible for equipment maintenance will be educated on requirements for tracking, inspecting, maintaining, and documenting electric beds and PCREE. The Administrator/designee will audit the electric bed and PCREE preventive maintenance program monthly for three months to verify required inspections and maintenance are current and appropriately documented. Identified concerns will be corrected and results reported through the facility's QAPI process.	08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING **04 - MECHANICAL...** B. WING	(X3) DATE SURVEY COMPLETED **07/27/2026**

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K0000 Bldg. 04	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/27/2026. At the time of this survey, Little Falls Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K0000		08/31/2026

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 reverse for further 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.

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K0000 Bldg. 04	Continued from page 1 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. The facility was inspected as two buildings: Building 04 - The West building is a 1 story building without a basement and was determined to be Type II(111) construction. Since Building 03 was built under the 2000 edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code and Building 04 was built to the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code the two buildings were inspected separately. The facility has a capacity of 64 beds and had a census of 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		08/31/2026
K0921 SS = F Bldg. 04	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is	K0921	The facility completed an inventory of electric beds and patient-care-related electrical equipment (PCREE), including nebulizers, oxygen concentrators, portable suction units, and other applicable electrical medical equipment. Equipment was reviewed to verify required inspection and maintenance was completed and documented. The Environmental Services Director/designee will maintain a current inventory and preventive	08/31/2026

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K0921 SS = F Bldg. 04	Continued from page 2 performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities Code 2012 Edition, section 10.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/27/2026 at 10:34 AM, it was revealed that the facility failed to provide documentation on the electric beds for all residents, and that PCREE such as nebulizers, oxygen concentrators, portable suction units, and other electrical medical equipment was present at the facility was inspected and maintained. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0921	Continued from page 2 maintenance schedule for electric beds and PCREE and ensure required inspections, maintenance, and documentation are completed. Environmental Services staff responsible for equipment maintenance will be educated on requirements for tracking, inspecting, maintaining, and documenting electric beds and PCREE. The Administrator/designee will audit the electric bed and PCREE preventive maintenance program monthly for three months to verify required inspections and maintenance are current and appropriately documented. Identified concerns will be corrected and results reported through the facility's QAPI process.	08/31/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 3, 2026

Administrator
LITTLE FALLS CARE CENTER
1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

RE: CCN: 245399
Cycle Start Date: July 30, 2026

Dear Administrator:

On August 18, 2026, we informed you of imposed enforcement remedies.

On July 30, 2026, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the revisit findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 2, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 2, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 2, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of August 18, 2026, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your

facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 2, 2026.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Deborah Willis, Regional Operations Supervisor
Health Regulation Division
Minnesota Department of Health
St. Cloud District Office
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Deborah.Willis@state.mn.us
Office: (651) 201-3793

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or
Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 30, 2027 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to

request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

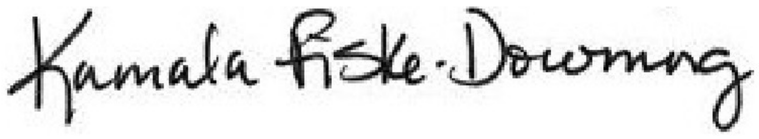
INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 7/26/26 through 7/30/26, a survey for compliance with CFR §483.73(b)(6), Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E0000		
F0000	INITIAL COMMENTS On 7/26/26 through 7/30/26, a standard recertification survey (S5459041) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: NO deficiencies were cited. H53993427C/IQIES#: 3044439 H553993428C/IQIES#: 3041144 H53993434C/IQIES#: 2654380 H53993434C/IQIES#: 2653519 H53993426C/IQIES#: 3068268 H539923429C/IQIES#: 2998972 H53993433C/IQIES#: 2802683	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026

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F0000	Continued from page 1 H53993430C/IQIES#: 2798531 H53993431C/IQIES#: 2797371 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0755 SS = G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F0755		

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F0755 SS = G	Continued from page 2 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: 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 3/16/26, 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 pregablin 100mg by mouth three times a day (TID) for chronic pain was ordered 6/25/25	F0755		

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F0755 SS = G	Continued from page 3 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. 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	F0755		

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F0755 SS = G	Continued from page 4 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 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)	F0755		

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F0755 SS = G	Continued from page 5 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 6/15/26, 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	F0755		

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F0755 SS = G	Continued from page 6 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 6/2/26, indicated R22 had moderate cognitive impairment, diagnoses included COPD, spondylosis (causes pain	F0755		

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F0755 SS = G	Continued from page 7 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. 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.	F0755		

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F0755 SS = G	Continued from page 8 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.	F0755		
E0007 SS = F	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3),	E0007		

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E0007 SS = F	Continued from page 9 §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the emergency preparedness plan included their vulnerable patient population including persons at-risk and the type of services required to meet their needs. This had the potential to affect all residents residing in the facility. Findings include: The facility's emergency preparedness (EP) plan was reviewed and lacked collaboration with their facility assessment to include the patient population served within the facility and their unique vulnerabilities in the event of an emergency or disaster. During interview on 7/30/26 at 8:15 a.m. Administrator stated they did not have the patient population calculated or included in their EP plan. A facility policy was request but none provided.	E0007		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0036 SS = F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must	E0036		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0036 SS = F	Continued from page 11 develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interviews, the facility failed to develop and maintain an emergency preparedness (EP) training and testing program which was based on the emergency plan, risk assessment, policies and procedures. This had the potential to affect all residents residing at the facility. Findings include: During review of the facility's EPP, it was revealed the EP program lacked evidence of a required full-scale community-based, or a tabletop exercise since January 2025. On 5/22/26 at 3:49p.m., the administrator stated no exercises have been completed within the past year. A policy was requested, however, none provided.	E0036		
E0037 SS = F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff,	E0037		

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E0037 SS = F	Continued from page 12 individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E0037		

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E0037 SS = F	Continued from page 13 (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency	E0037		

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E0037 SS = F	Continued from page 14 procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E0037		

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E0037 SS = F	Continued from page 15 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is NOT MET as evidenced by: Based on document review and interviews, the facility failed to develop and maintain emergency preparedness plan (EPP) training program which was based on the emergency plan, risk assessment, policies, and procedures. This had the potential to affect all residents residing at the facility and staff members. Findings include: During review of the facility's initial EP program training, nursing assistant (NA)-C lacked evidence initial EP training was completed upon hire. Further, licensed practical nurse (LPN)-A lacked evidence of EP annual training. On 7/31/26 at 10:00 a.m. business office manager stated there was no evidence NA-C completed the initial EP training. Further, there was no annual EP training found for LPN-A A policy related to EPP was requested, and none was provided.	E0037		
E0039 SS = F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to	E0039		

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E0039 SS = F	Continued from page 16 test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or	E0039		

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E0039 SS = F	Continued from page 17 (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or	E0039		

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E0039 SS = F	Continued from page 18 (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.	E0039		

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E0039 SS = F	Continued from page 19 *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:	E0039		

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E0039 SS = F	Continued from page 20 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the	E0039		

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E0039 SS = F	Continued from page 21 emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E0039		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0039 SS = F	Continued from page 22 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.	E0039		

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E0039 SS = F	Continued from page 23 This REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the facility failed to develop and maintain an emergency preparedness plan (EPP) training and testing program which wa based on the emergency plan, risk assessment, policies and procedures. This had the potential to affect all residents residing at the facility. Findings include: During review of the facility's EPP, the facility last performed an exercise in January 2025. During interview on 7/30/26 at 8:15 a.m. Administrator stated they had not completed any exercises since January 2025. A policy was requested, however, none provided.	E0039		
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical	F0851		

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F0851 SS = F	Continued from page 24 nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: 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 visitors The 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 10/26/25 Saturday 11/29/25 Saturday 12/13/25 Sunday 12/14/25 Sunday 12/28/25	F0851		

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F0851 SS = F	Continued from page 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 1/3/26 Saturday 1/17/26 Sunday 1/18/26 Saturday 1/24/26 Sunday 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.	F0851		
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection	F0880		

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F0880 SS = F	Continued from page 26 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by	F0880		

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F0880 SS = F	Continued from page 27 staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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.	F0880		
F0580 SS = E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F0580		

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F0580 SS = E	Continued from page 28 physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: 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	F0580		

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F0580 SS = E	Continued from page 29 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 6/15/26, 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	F0580		

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F0580 SS = E	Continued from page 30 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 3/16/26, 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 pregablin 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	F0580		

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F0580 SS = E	Continued from page 31 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 R20 currently out of pregabalin and hydromorphone, and R20 complained of "not feeling	F0580		

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F0580 SS = E	Continued from page 32 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 6/2/26, 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	F0580		

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F0580 SS = E	Continued from page 33 (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-recommendatio n) 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.	F0580		

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F0580 SS = E	Continued from page 34 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.	F0580		
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: 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 AM Lunch - Noon Supper - 5 PM Evening - 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 degrees	F0804		

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F0804 SS = E	Continued from page 35 Potato - 108 degrees Sliced Carrots - 94 Jello - 53 degrees Cranberry juice - 60 degrees Ice water - 52 degrees DM 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 Lindberg 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 116 - both cold and hot food was under a plastic cover and served on the same plate Shredded beef - 121.6 degrees Tater Tots - 98.4 degrees Salad - 67.5 degrees Strawberries with whipped topping - 64.2 degrees Apple juice - 54.7 degrees Room tray for room 120 Shredded beef on bun - 118.2 degrees Green beans - 104.5 degrees Strawberries with whipped topping - 64.6 degrees Apple juice 52.9 degrees CNA-A was unable to state what the safe and desirable temperature of each food should be.	F0804		

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F0804 SS = E	Continued from page 36 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 316: Eggs-87 degrees Fahrenheit (˚F) Toast-82 ˚F Bacon-78 ˚F Coffee-114 ˚F Milk-58 ˚F Tray #2 labeled Room 303: Pancakes-92 ˚F Sausage-93 ˚F	F0804		

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F0804 SS = E	Continued from page 37 Bacon-86 ˚F Strawberries-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 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.	F0804		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656		

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F0656 SS = D	Continued from page 38 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: 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.	F0656		

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F0656 SS = D	Continued from page 39 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 Francis 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.	F0656		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F0692		

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F0692 SS = D	Continued from page 40 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: 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 6/15/26, indicted R4 admitted to the facility on 9/26/23, was cognitively intact and had the following diagnoses: Chronic Obstructive Pulmonary Disease, Heart failure, Dysphagia and Parkinsonism. R4's Nutritional Risk assessment dated 6/8/26 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 6/8/26, 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	F0692		

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F0692 SS = D	Continued from page 41 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 (initiated11/4/24). 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	F0692		

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F0692 SS = D	Continued from page 42 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 185.0 3/17/2026 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.	F0692		

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F0692 SS = D	Continued from page 43 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 weight. RD stated R4 should lso 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	F0692		

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F0692 SS = D	Continued from page 44 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.	F0692		
E0030 SS = C	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E0030		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0030 SS = C	Continued from page 45 (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following:	E0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026

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LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345

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E0030 SS = C	Continued from page 46 (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is NOT MET as evidenced by: Base on interview and document review the facility failed to ensure the emergency preparedness plan (EPP) included a current listing of names and contact information. This had the potential to affect all residents residing in the facility. Findings included: The facility's EPP was reviewed and included a list of contact information; however, key current staff were not listed. During interview on 7/30/26 at 8:15 a.m. Administrator stated the contact information included was outdated and he had updated the list. A policy was requested; however, none was provided.	E0030		
E0034 SS = C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that	E0034		

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E0034 SS = C	Continued from page 47 complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure their emergency preparedness plan (EPP) included a means for providing information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee. Findings inclued: A review of the facility EPP lacked evidence the communication plan had a procedure to provide information regarding the facility's occupancy, needs, and ability to provide assistance to outside sources, such as the authority having jurisdiction over the facility, the incident command center or other designee. During interview on 7/30/26 at 8:15 a.m. Administrator stated he had not share occupancy in years. This was not included in the EPP. A policy was requested; however, none was provided.	E0034		
F0572 SS = C	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication.	F0572		

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F0572 SS = C	Continued from page 48 §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were promptly informed of changes to the Nursing Home Resident Bill 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.	F0572		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On (7/26/26 through 7/30/26), a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: NO	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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20000	Continued from page 1 deficiencies were cited. H53993427C/IQIES#: 3044439 H553993428C/IQIES#: 3041144 H53993434C/IQIES#: 2654380 H53993434C/IQIES#: 2653519 H53993426C/IQIES#: 3068268 H539923429C/IQIES#: 2998972 H53993433C/IQIES#: 2802683 H53993430C/IQIES#: 2798531 H53993431C/IQIES#: 2797371 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	20000		

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20000	Continued from page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	20265		

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20265	Continued from page 3 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 6/15/26, 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	20265		

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20265	Continued from page 4 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 3/16/26, 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 pregablin 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	20265		

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20265	Continued from page 5 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 R20 currently out of pregabalin and hydromorphone, and R20 complained of “not feeling well”, SOB, and “skin crawling”. The nurse	20265		

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20265	Continued from page 6 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 6/2/26, 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	20265		

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20265	Continued from page 7 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-recommendatio n) 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 (situation, background, action, recommendation) form for any missed medications and/or change in condition.	20265		

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20265	Continued from page 8 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	20555		

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LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345**

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20555	Continued from page 9 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 Francis 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	20555		

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20555	Continued from page 10 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		
20965	Dietary Service -Nutritional Status CFR(s): MN Rule 4658.0600 Subp. 2 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 6/15/26, indicted R4 admitted to the facility on 9/26/23, was cognitively intact and had the following diagnoses: Chronic Obstructive Pulmonary Disease, Heart failure, Dysphagia and Parkinsonism. R4's Nutritional Risk assessment dated 6/8/26 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 6/8/26, indicated R4 was not on a prescribed weight-loss regimen and received a mechanically altered diet.	20965		

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20965	Continued from page 11 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 (initiated11/4/24). 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	20965		

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20965	Continued from page 12 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 185.0 3/17/2026 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	20965		

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20965	Continued from page 13 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 weight. RD stated R4 should lso 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	20965		

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20965	Continued from page 14 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20965		
21025	Food Temperatures CFR(s): MN Rule 4658.0615 Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	21025		

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21025	Continued from page 15 times were as follows: Breakfast - 8 AM Lunch - Noon Supper - 5 PM Evening - 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 degrees Potato - 108 degrees Sliced Carrots - 94 Jello - 53 degrees Cranberry juice - 60 degrees Ice water - 52 degrees DM 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 Lindberg 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 116 - both cold and hot food was under a plastic cover and served on the same plate Shredded beef - 121.6 degrees Tater Tots - 98.4 degrees Salad - 67.5 degrees Strawberries with whipped topping - 64.2 degrees	21025		

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21025	Continued from page 16 Apple juice - 54.7 degrees Room tray for room 120 Shredded beef on bun - 118.2 degrees Green beans - 104.5 degrees Strawberries with whipped topping - 64.6 degrees Apple 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 316: Eggs-87 degrees Fahrenheit (˚F)	21025		

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21025	Continued from page 17 Toast-82 ˚F Bacon-78 ˚F Coffee-114 ˚F Milk-58 ˚F Tray #2 labeled Room 303: Pancakes-92 ˚F Sausage-93 ˚F Bacon-86 ˚F Strawberries-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 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated on proper use of thermometers, and that they are made available, to ensure food is at the appropriate temperature prior to serving. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing	21375		

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21375	Continued from page 18 home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated on handling soiled linens. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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.	21550		

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21550	Continued from page 19 Findings include: R20 R20’s annual Minimum Data Set (MDS), dated 3/16/26, 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 pregablin 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	21550		

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21550	Continued from page 20 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. 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 hydromorphone 4mg BID, “He is now out of the	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345**

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21550	Continued from page 21 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.,	21550		

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21550	Continued from page 22 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 6/15/26, 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	21550		

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21550	Continued from page 23 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 6/2/26, 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.	21550		

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21550	Continued from page 24 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. 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.	21550		

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21550	Continued from page 25 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21800	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute144.651 Subd. 4 Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01,	21800		

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21800	Continued from page 26 the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were promptly informed of changes to the Nursing Home Resident Bill 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. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure poster is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

9/25/2026

Administrator
Little Falls Care Center
1200 first Avenue Northeast
Little Falls, MN 56345

RE: Survey 235D4C-H3
CCN: 245399
HFID: 00382

Dear Administrator:

On September 3, 2026, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $850.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on September 3, 2026 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is . In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $197.20, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Minnesota Department of Health in the amount of $1047.20 within 15 days of the receipt of this notice.

Please send a copy of this letter and the check to:

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

PO Box 64975
Financial Management
St. Paul MN 55164-0975
Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

cc: Sarah Lane, Health Program Rep Senior
Shellae Dietrich, Health Program Manager
Joanne Simon, Health Program Rep Principal
Kami Fiske-Downing, Health Program Rep Senior
HRD Deposit Team

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 25, 2026

Administrator
LITTLE FALLS CARE CENTER
1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

RE: CCN: 245399
Cycle Start Date: July 30, 2026

Dear Administrator:

On August 18, 2026, we notified you a remedy was imposed. On September 3, 2026 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 3, 2026.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective September 2, 2026 be discontinued as of September 3, 2026. (42 CFR 488.417 (b))

In our letter of August 18, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 2, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/01/2026**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On (9/1/26), an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on (7/30/26) by the Minnesota Department of Health (MDH). Your facility was found to be NOT IN compliance with the MN State Nursing Home Licensure. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.	20000		09/03/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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20000	Continued from page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		09/03/2026
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to notify the provider of missed dosses of medications for 1 of 4 residents (R20) reviewed for medication administration.	20265	Corrected	09/03/2026

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20265	Continued from page 2 Findings include: R20’s quarterly Minimum Data Set (MDS) dated 8/26/26, indicated R20 was severely cognitively impaired, and had the following diagnoses: type 2 Diabetes with diabetic neuropathy (nerve damage in legs and feet), anxiety, and received scheduled pain medication regimen. R20’s order recap report dated 9/1/26, indicated R20 was taking the following medications long term: -Hydromorphone HCL oral tablet 4 milligrams (MG): Give 4 mg by mouth two times a day. -Pregabalin oral capsule 100MG: Give 100mg by mouth three times a day. R20’s Medical Administration Record (MAR) printed 9/1/26, indicated R20 was NOT administered medication doses listed below: -Hydromorphone 4mg 8/27/26-HS dose -Pregabalin 100 mg 8/27/26-HS dose 8/28/26-AM dose R20’s medical record lacked any documentation or explanation of why the above doses were missed or whether the provider was updated of the missing medications. On 9/1/26 at 4:09 p.m., the director of nursing (DON) and the licensed practical nurse manager (LPN)-A confirmed R20’s had not received their dose of hydromorphone and 2 doses of pregabalin listed above, and the provider had not been notified of the missed medication doses. The DON and LPN-A confirmed they had the medications in the building, however, on 8/27/26, a nurse had entered a new order earlier in the day, for the already prescribed medications, to be signed by the physician for hydromorphone and pregabalin, and because the order had not been signed by the physician, the trained medical assistant (TMA) was not able to give the medication or document why because they do not allow TMA’s to document in their charting system. The DON and LPN-A stated they would have expected the TMA to go to the nurse on duty and report the inability to give and/or	20265		09/03/2026

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20265	Continued from page 3 document on the why the medication doses were missed. On 9/1/26 at 4:28p.m., TMA-A confirmed they had been working the night of two of the three missed doses. TMA-A stated they pass medications regularly on the unit and knew that R20 was due to get those medications. When TMA-A went to pass medications, they saw that the hydromorphone and pregabalin were both pending order confirmation, and TMA-A stated they had no way to document why the medication was not given, however, they had gone to the registered nurse (RN)-A on duty and reported they were unable to administer the medications. TMA-A stated RN-A said they would make note of the incident and didn't mention whether they called the provider. Attempts were made to contact RN-A, however, were unsuccessful. On 9/1/26 at approximately 4:35 p.m., the DON stated their expectation was for the TMA to report to the RN on duty and for the RN on duty to call the provider to update them about the situation and request orders/clarifications, and for the RN to document the reason why the medication was not provided, and if the provider was updated and their instructions from there. DON confirmed there was no documentation to explain what happened, and no evidence the provider was ever notified of the missed doses or need for the order to be signed. The medication administration policy last reviewed 8/7/23, indicated the following: - if the resident refused the medication or is unable to take the medication document the refusal in the MAR and explained the reason why them ed was not given. -if a resident's medication is changed or discontinued by the physician the nurse will record the medication change the mar and the medication will be removed from the medication cart. -Physicians will be notified of medication errors, if a significant medication error occurs the physician will be notified immediately for further treatment orders. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance.	20265		09/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/01/2026**

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20265	Continued from page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		09/03/2026
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 1 of 4 residents (R20) reviewed for medication administration. Findings include: R20’s quarterly Minimum Data Set (MDS) dated 8/26/26, indicated R20 was severely cognitively impaired, and had the following diagnoses: type 2 Diabetes with diabetic neuropathy (nerve damage in legs and feet), anxiety, and received a scheduled pain medication regimen. R20’s order recap report dated 9/1/26, indicated R20 was taking the following medications long term: -Hydromorphone HCL oral tablet 4 milligrams (MG): Give 4 mg by mouth two times a day. -Pregabalin oral capsule 100MG: Give 100mg by mouth three times a day. R20’s Medical Administration Record (MAR) printed 9/1/26, indicated R20 was NOT administered the medication doses listed below: -Hydromorphone 4mg 8/27/26-HS(hour of sleep) dose -Pregabalin 100 mg 8/27/26-HS dose 8/28/26-AM dose R20’s Medical record lacked any documentation or explanation of why the above doses were missed. On 9/1/26 at 4:09 p.m., the director of nursing (DON) and the licensed practical nurse manager	21550	Corrected	09/03/2026

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21550	Continued from page 5 (LPN)-A confirmed R20's had not received their dose of hydromorphone and 2 doses of pregabalin listed above. The DON and LPN-A confirmed they had the medications in the building, however, on 8/27/26, a nurse had entered a new order earlier in the day, for the already prescribed medications, to be signed by the physician for hydromorphone and pregabalin, and because the order had not been signed by the physician, the trained medical assistant (TMA) was not able to give the medication or document why because they do not allow TMA's do document progress notes in their charting system. The DON and LPN-A stated they would have expected the TMA to go to the nurse on duty and report the inability to give and/or document on the why the medication doses were missed. On 9/1/26 at 4:28p.m., TMA-A confirmed they had been working the night of two of the three missed doses. TMA-A stated they pass medications regularly on the unit and knew that R20 was due to get those medications. When TMA-A went to pass medications, they saw that the hydromorphone and pregabalin were both pending order confirmation, and TMA-A stated they had no way to document why the medication was not given, however, they had gone to the registered nurse (RN)-A on duty and reported they were unable to administer the medications. TMA-A stated RN-A said they would make note of the incident and didn't mention whether or not they called the provider. Attempts were made to contact RN-A, however, were unsuccessful. On 9/1/26 at approximately 4:35 p.m., the DON stated their expectation was for the TMA to report to the RN on duty and for the RN on duty to call the provider to update them about the situation and request orders/clarifications, and for the RN to document the reason why the medication was not provided, and if/when the provider was updated and their instructions from there. DON confirmed there was no documentation to explain what happened, and no evidence the provider was ever notified of the missed doses or need for the order to be signed. The medication administration policy last reviewed 8/7/23, indicated the following: - if the resident refused the medication or is unable to take the medication document the refusal in the MAR and explain the reason why them medication was not given. -if a resident's medication is changed or	21550		09/03/2026

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21550	Continued from page 6 discontinued by the physician the nurse will record the medication change the mar and the medication will be removed from the medication cart. -Physicians will be notified of medication errors, if a significant medication error occurs the physician will be notified immediately for further treatment orders. SUGGESTED METHOD OF CORRECTION: The administrator, DON, or designee could ensure policy is updated and staff is educated. The facility could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		09/03/2026

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E0000	Initial Comments On (9/1/26), an onsite revisit was conducted to determine compliance with CMS Appendix Z Emergency Preparedness Requirements CFR §483.73, cited during a standard recertification survey exited on (7/30/26). The facility was found to be IN compliance.	E0000		09/03/2026
F0000	INITIAL COMMENTS On (9/1/26), an onsite revisit was conducted to follow up on deficiencies related to a standard recertification survey (S#5399042) exited on (7/30/26). The facility was found to be NOT in compliance with the requirements of §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The following tags were recited: (FTAG). F755 F580 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		09/03/2026
F0580 SS = E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F0580	R20's Physician was notified of the missed doses of Hydromorphone and Pregabalin. The facility failed to notify the provider of missed doses of medications for R20. All residents have the potential to be affected by the deficient practice.	09/03/2026

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 reverse for further 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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F0580 SS = E	Continued from page 1 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by:	F0580	Continued from page 1 RN-A (Agency LPN that was working during the identified incident) has been educated on the revised medication supply and pending order process. This Agency LPN has also been re-educated on the Medication Administration Policy and if a significant medication error occurs, the physician will be notified immediately for further treatment orders. All Nurses will be re-educated or before the start of their next shift on the Medication Administration Policy and that if a significant medication error occurs, the physician will be notified immediately for further treatment orders. Missing a dose of a controlled substance would be an incident that the physician must be notified of. The notification to the provider must be documented in the resident's EHR. A Notify of Changes Audit will be completed 2x/week for 4 weeks, then weekly for 4 weeks. The results will be brought to QAPI for further review and recommendations. The DON or designee will oversee the auditing. Any identified concerns will be corrected immediately, and re-education/corrective action provided as needed.	09/03/2026

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F0580 SS = E	Continued from page 2 Based on interview and document review the facility failed to notify the provider of missed dosses of medications for 1 of 4 residents (R20) reviewed for medication administration. Findings include: R20’s quarterly Minimum Data Set (MDS) dated 8/26/26, indicated R20 was severely cognitively impaired, and had the following diagnoses: type 2 Diabetes with diabetic neuropathy (nerve damage in legs and feet), anxiety, and received scheduled pain medication regimen. R20’s order recap report dated 9/1/26, indicated R20 was taking the following medications long term: -Hydromorphone HCL oral tablet 4 milligrams (MG): Give 4 mg by mouth two times a day. -Pregabalin oral capsule 100MG: Give 100mg by mouth three times a day. R20’s Medical Administration Record (MAR) printed 9/1/26, indicated R20 was NOT administered medication doses listed below: -Hydromorphone 4mg 8/27/26-HS dose -Pregabalin 100 mg 8/27/26-HS dose 8/28/26-AM dose R20’s medical record lacked any documentation or explanation of why the above doses were missed or whether the provider was updated of the missing medications. On 9/1/26 at 4:09 p.m., the director of nursing (DON) and the licensed practical nurse manager (LPN)-A confirmed R20’s had not received their dose of hydromorphone and 2 doses of pregabalin listed above, and the provider had not been notified of the missed medication doses. The DON and LPN-A confirmed they had the medications in the building, however, on 8/27/26, a nurse had entered a new order earlier in the day, for the already prescribed medications, to be signed by the physician for hydromorphone and pregabalin, and because the order had not been signed by the physician, the trained medical assistant (TMA) was	F0580		09/03/2026

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F0580 SS = E	Continued from page 3 not able to give the medication or document why because they do not allow TMA's to document in their charting system. The DON and LPN-A stated they would have expected the TMA to go to the nurse on duty and report the inability to give and/or document on the why the medication doses were missed. On 9/1/26 at 4:28p.m., TMA-A confirmed they had been working the night of two of the three missed doses. TMA-A stated they pass medications regularly on the unit and knew that R20 was due to get those medications. When TMA-A went to pass medications, they saw that the hydromorphone and pregabalin were both pending order confirmation, and TMA-A stated they had no way to document why the medication was not given, however, they had gone to the registered nurse (RN)-A on duty and reported they were unable to administer the medications. TMA-A stated RN-A said they would make note of the incident and didn't mention whether they called the provider. Attempts were made to contact RN-A, however, were unsuccessful. On 9/1/26 at approximately 4:35 p.m., the DON stated their expectation was for the TMA to report to the RN on duty and for the RN on duty to call the provider to update them about the situation and request orders/clarifications, and for the RN to document the reason why the medication was not provided, and if the provider was updated and their instructions from there. DON confirmed there was no documentation to explain what happened, and no evidence the provider was ever notified of the missed doses or need for the order to be signed. The medication administration policy last reviewed 8/7/23, indicated the following: - if the resident refused the medication or is unable to take the medication document the refusal in the MAR and explained the reason why them ed was not given. -if a resident's medication is changed or discontinued by the physician the nurse will record the medication change the mar and the medication will be removed from the medication cart. -Physicians will be notified of medication errors, if a significant medication error occurs the physician will be notified immediately for further treatment orders.	F0580		09/03/2026

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F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: 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 1 of 4 residents (R20) reviewed for medication administration. Findings include: R20’s quarterly Minimum Data Set (MDS) dated 8/26/26, indicated R20 was severely cognitively impaired, and had the following diagnoses: type 2 Diabetes with diabetic neuropathy (nerve damage in legs and feet), anxiety, and received a scheduled pain medication regimen.	F0755	R20 missed a dose of Hydromorphone and two doses of Pregabalin due to the order pending physician signature and not showing as active in the EMAR. The order was corrected to be active in the Electronic Health Record and the R20 received the next scheduled doses. The facility failed to implement a system to ensure all medications are consistently acquired, received, and administered. All residents with orders for controlled substances have the potential to be affected by the deficient practice. The specific TMA that did not administer the R20's medications, due to the pending status, received immediate education upon identifying the controlled substance that was not administered per order. RN-A (Agency LPN that was working during the identified incident) has been educated on the revised medication supply and pending order process. This Agency LPN has also been re-educated on the Medication Administration Policy and if a significant medication error occurs the physician will be notified immediately for further treatment orders. All residents will have pending orders confirmed, discontinued, or E-signed each shift by the nurse. All TMAs and Nurses have been re-educated on medication supply process. This process has been reviewed and revised to include orders in a pending status. All TMAs and Nurses have access to easily identify any pending orders on their home/portal within the EMAR/ETAR/Beh Tab. All TMAs and Nurses have been re-educated on the Medication Administration Policy and that a provider must be notified of any significant medication errors, such as a missing controlled substance dose. Casual and Part-Time staff will be educated prior to working their next shift. All agency staff will be educated prior to working their shift. The LPN or RN Nurse Managers will verify that there are no pending orders prior to leaving the facility each weekday. This will continue as part of their daily duties.	09/03/2026

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F0755 SS = D	Continued from page 5 R20's order recap report dated 9/1/26, indicated R20 was taking the following medications long term: -Hydromorphone HCL oral tablet 4 milligrams (MG): Give 4 mg by mouth two times a day. -Pregabalin oral capsule 100MG: Give 100mg by mouth three times a day. R20's Medical Administration Record (MAR) printed 9/1/26, indicated R20 was NOT administered the medication doses listed below: -Hydromorphone 4mg 8/27/26-HS(hour of sleep) dose -Pregabalin 100 mg 8/27/26-HS dose 8/28/26-AM dose R20's Medical record lacked any documentation or explanation of why the above doses were missed. On 9/1/26 at 4:09 p.m., the director of nursing (DON) and the licensed practical nurse manager (LPN)-A confirmed R20's had not received their dose of hydromorphone and 2 doses of pregabalin listed above. The DON and LPN-A confirmed they had the medications in the building, however, on 8/27/26, a nurse had entered a new order earlier in the day, for the already prescribed medications, to be signed by the physician for hydromorphone and pregabalin, and because the order had not been signed by the physician, the trained medical assistant (TMA) was not able to give the medication or document why because they do not allow TMA's do document progress notes in their charting system. The DON and LPN-A stated they would have expected the TMA to go to the nurse on duty and report the inability to give and/or document on the why the medication doses were missed. On 9/1/26 at 4:28p.m., TMA-A confirmed they had been working the night of two of the three missed doses. TMA-A stated they pass medications regularly on the unit and knew that R20 was due to get those medications. When TMA-A went to pass medications, they saw that the hydromorphone and pregabalin were both pending order confirmation, and TMA-A stated they had no way to document why the medication was not given, however they had gone to the registered nurse (RN)-A on duty and reported they were unable to administer the	F0755	Continued from page 5 A Pending Order Audit will be completed 5x/week for four weeks, then weekly for four weeks. The findings of the audits will be brought to QAPI for review. The DON will oversee the compliance of the audits and medication ordering and pending orders process.	09/03/2026

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F0755 SS = D	Continued from page 6 medications. TMA-A stated RN-A said they would make note of the incident and didn't mention whether or not they called the provider. Attempts were made to contact RN-A, however, were unsuccessful. On 9/1/26 at approximately 4:35 p.m., the DON stated their expectation was for the TMA to report to the RN on duty and for the RN on duty to call the provider to update them about the situation and request orders/clarifications, and for the RN to document the reason why the medication was not provided, and if/when the provider was updated and their instructions from there. DON confirmed there was no documentation to explain what happened, and no evidence the provider was ever notified of the missed doses or need for the order to be signed. The medication administration policy last reviewed 8/7/23, indicated the following: - if the resident refused the medication or is unable to take the medication document the refusal in the MAR and explain the reason why them medication was not given. -if a resident's medication is changed or discontinued by the physician the nurse will record the medication change the mar and the medication will be removed from the medication cart. -Physicians will be notified of medication errors, if a significant medication error occurs the physician will be notified immediately for further treatment orders.	F0755		09/03/2026