DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 21, 2025

Administrator
Little Falls Care Center
1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

RE: CCN: 245399
Cycle Start Date: July 9, 2025

Dear Administrator:

On September 18, 2025, we notified you a remedy was imposed. On September 9, 2025, the Minnesota Departments of Health 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 22, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 9, 2025 be discontinued as of September 22, 2025. (42 CFR 488.417 (b))

In our letter of September 18, 2025, 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 9, 2025. 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
Compliance Analyst | Federal Enforcement

Health Regulation Division

**Minnesota Department of Health**

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

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November 21, 2025

Administrator
Little Falls Care Center
1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

Re: Reinspection Results
Event ID: 1D4965H1

Dear Administrator:

On October 1, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 22, 2025. At this time these correction orders were found corrected.

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
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DEPARTMENT OF HEALTH

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September 11, 2025

Administrator
Little Falls Care Center
1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

RE: CCN: 245399
Cycle Start Date: July 9, 2025

Dear Administrator:

On August 22, we informed you that we may impose enforcement remedies.

On August 22, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby 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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 9, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 9, 2025. They will

also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 9, 2025.

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 October 9, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Little Falls Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 9, 2025. 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)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 9, 2026 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 Steven Delich, Program Representative at (312) 886-5216. 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

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

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September 11, 2025

Administrator
Little Falls Care Center
1200 FIRST AVENUE NORTHEAST
LITTLE FALLS, MN 56345

Re: State Nursing Home Licensing Orders
Event ID: 1D4965-H1

Dear Administrator:

The above facility survey was completed on August 22, 2025 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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
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<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**08/22/2025** |
|---|---|---|---|

| 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<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On 8/20/25 through 8/22/25, a complaint 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 Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. | 20000 | | 09/11/2025 |



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

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| 20000 | Continued from page 1<br><br>The following complaint was reviewed with no deficiency issued. H53992560C (2591888).<br><br>As a result of the investigation, licensing orders were cited at 0265 and 0565.<br><br>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.<br><br>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/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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>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 | 20000 | | |
| 20265 | Notification of Chg in Resident Health Status<br><br>CFR(s): MN Rule 4658.0085<br><br>A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician | 20265 | Corrected | 09/22/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**08/22/2025** |
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| 20265 | Continued from page 2<br>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:<br><br>A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>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;<br><br>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;<br><br>D. a decision to transfer or discharge the resident from the nursing home; or<br><br>E. expected and unexpected resident deaths.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to notify physician and resident representative timely of a new injury for 1 of 3 residents (R1) reviewed.<br><br>Findings include:<br><br>R1’s quarterly Minimal Data Set (MDS) dated 5/27/25, indicated R1 had diagnoses which included traumatic subdural hemorrhage, cerebral infarction, anxiety disorder, and had severely impaired cognition.<br><br>R1’s skin incident report dated 8/10/25, revealed registered nurse (RN)-D was called into R1’s room to assess a skin tear to left front of lower shin. Staff had explained that they were getting R1 up and ready for the day and she pulled her pants down to change | 20265 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**08/22/2025** |
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| 20265 | Continued from page 3<br>them. Upon lowering her pants, staff noticed that there was blood on the sheet and when she looked where it was coming from, staff observed a skin tear. RN-D completed wound care by cleaning and covering with bandage. R1 denied any pain in the area, but upon completing wound care R1 was seen wincing in pain. Both RN-D and staff assisted by applying Tubi grips to both lower extremities and proceeded to continue cares. Injuries observed at the time of the incident was a skin tear to left lower leg, RN-D cleansed wound with wound cleanser, skin flap was approximated with Q-Tip and covered with non-adherent pad, leg was then wrapped with rolled gauze and secured with tape, Tubi-grip placed over leg to hold dressing in place. Further incident report revealed R1's physician was notified on 8/12/25 at 2:05 p.m., and there was no evidence of resident representative being notified.<br><br>R1's progress note dated 8/10/25 at 9:23 p.m., R1's left leg skin tear dressing was removed by a nursing assistant because R1's daughter wanted to look at the wound. R1's record lacked evidence of R1's representative being notified prior and notification to resident's physician.<br><br>On 8/20/25 at 12:16 p.m., R1's resident representative (RR) stated she was at the facility on 8/09/25, and when she came to the facility on 8/10/25, RR stated she inquired to staff about a bruise on her arm and that was when the staff notified her of the skin tear on R1's leg. RR stated typically she would receive a phone call from the staff on incidents, but she was not notified of the skin tear until later in the day.<br><br>On 8/20/25 at 3:52 p.m., RN-A stated staff were expected to notify provider and family as soon as staff were aware of any new skin impairments.<br><br>On 8/20/25 at 9:25 a.m., licensed practical nurse (LPN)-A stated new injuries or skin impairments were expected to be reported to the charge nurse and they would complete an incident report and inform the unit case managers and director of nursing (DON), and the DON would notify the physician and family as soon as the DON was made aware.<br><br>On 8/21/25 at 10:08 a.m., RN-B stated new skin impairments were expected to be reported to the physician and family immediately or within your shift depending on severity. The floor nurse would be expected to complete an incident report and part of the incident report would be notifications to appropriate parties such as physician, family and DON. | 20265 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**08/22/2025** |
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| 20265 | Continued from page 4<br>On 8/21/25 at 3:15 p.m., RN-C stated for new skin impairments, the floor nurse was expected to complete a risk management (incident report), provide aid and treatment to the injury, notify DON and nurse on call. Further, RN-C stated the physician, and resident representative would be expected to be notified immediately as well.<br><br>On 8/21/25 at 4:40 p.m., attempted interview with R1's provider was unsuccessful.<br><br>On 8/22/25 at 8:56 a.m., DON stated staff were expected to complete an incident report upon discovering a new skin impairment, and part of the document required staff to notify the physician and resident representative. DON stated RN-D discovered the skin tear in the early morning of 8/10/25 and passed on in report to the next shift because RN-D was unable to complete all tasks due to having a busy night. DON stated RR was upset she was not notified.<br><br>On 8/22/25 at 9:59 a.m., RN-D stated at approximately 5:30 a.m. on 8/10/25, RN-D was paged to go to R1's room and RN-D observed the skin tear. RN-D stated she assessed the wound and passed through report to the next shift of the update. RN-D stated she was not completed with her charting at 6:30 a.m. when her shift was over, so RN-D returned to the facility later that afternoon to complete the incident report. RN-D stated she was aware she did not notify R1's resident representative and "I am sure [RR] was not happy", and RN-D confirmed she did not notify R1's physician because, "it all happened so fast". Further, RN-D stated notifying the physician and resident representative was part of completing the incident report, and staff were expected to call nurse triage and leave a message for the resident's physician and notify the resident's representative.<br><br>On 8/26/25 at 11:30 a.m., return call from RN-E, nurse at R1's physician's office, RN-E confirmed the provider was not notified of R1's skin tear until a note was received from the facility a couple days later about a wound dressing.<br><br>A copy of the facility's notification policy was requested but facility failed to provide.<br><br>SUGGESTED METHOD OF CORRECTION: The facility could review policies and procedures and train staff related to notifications to the provider and resident representative timely of accidents or injuries. The Director of Nursing (or designee) could conduct measurable audits on residents health records and bring | 20265 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **Little Falls Care Center** | **1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345** |

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| 20265 | Continued from page 5<br>to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.<br><br>TIME PERIOD FOR CORRECTION: twenty-one (21) days. | 20265 | | |
| 20565 | Comprehensive Plan of Care; Use<br><br>CFR(s): MN Rule 4658.0405 Subp. 3<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and document review, the facility failed to ensure care plan interventions for transfers were implemented for 1 of 3 residents (R1) reviewed.<br><br>Findings include:<br><br>R1’s quarterly Minimal Data Set (MDS) dated 5/27/25, indicated R1 had diagnoses which included traumatic subdural hemorrhage, cerebral infarction, anxiety disorder, and R1 had severely impaired cognition.<br><br>R1’s care plan revised on 8/9/25, identified R1 had an activities of daily living (ADL) self- care deficit related to confusion due to recent stroke and staff were direct to ambulate R1 to meals as able with a single quad cane, gait belt, and contact guard assist, recommend another staff to follow with wheelchair and the nurse would document all attempts that fail. R1’s care plan also directed staff to ambulate R1 to and from the bathroom with assist of one and a single quad cane, gait belt, and contact guard assist, recommend another staff to follow with wheelchair and nurse to document all attempts that fail.<br><br>R1’s Progress Note dated 8/20/25, revealed no change in condition noted this shift. R1 required extensive assist of one with the non-mechanical sit to stand lift and R1 did not exhibit any behaviors. R1’s record lacked evidence of any failed attempts related to transfers or ambulation.<br><br>On 8/20/25 at 12:16 p.m., anonymous reporter (AR) stated R1 received outpatient therapy and R1 was provided with orders for facility staff to assist R1 with ambulating to and from the bathroom with a cane, as well as to and from meals as tolerated. AR stated the facility were not following R1’s care plan and had been transferring R1 using a non-mechanical stand lift. | 20565 | Corrected | 09/22/2025 |

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| 20565 | Continued from page 6<br><br>On 8/20/25 at 3:52 p.m., registered nurse (RN)-A stated R1 required assistance by staff for all activities of daily living (ADL), and R1's care plan at this time identified R1 required assistance by one staff member for stand and pivot transfers and utilizing a cane for ambulation. Further, RN-A stated at times R1 would be weaker and require more staff assistance with transfers and the use of a non-mechanical stand lift.<br><br>On 8/21/25 at 9:25 a.m. licensed practical nurse (LPN)-A stated R1 required assistance with all ADLs and required a non-mechanical sit to stand lift for transfers and depending on the day was able to stand and pivot but was unable to ambulate.<br><br>On 8/21/25 at 10:08 a.m., RN-B stated R1 was not resistive to cares and was usually easy to talk through tasks and allow staff to assist with tasks. RN-A stated R1 required a non-mechanical sit to stand lift for transfers assistance by one staff, and RN-A stated she had not witnessed R1 ambulate at the facility but R1 was able to ambulate in therapy.<br><br>On 8/22/25 at 12:00 p.m., nursing assistant (NA) stated R1 recently received new therapy orders directing staff to assist with ambulating to and from the restroom with a cane and gait belt. NA-A stated R1 often chooses which staff she prefers to ambulate for and if R1 was not compliant staff would often use the non-mechanical sit to stand lift to transfer.<br><br>On 8/21/25 at 12:15 p.m., NA-A was observed assisting R1 in her wheelchair to R1's room. NA-A asked R1 if she was able to walk to the bathroom and R1 stated "yes", so NA-A placed a gait belt around R1's waist and R1 stated she wanted to use her walker instead of the cane. R1 placed hands on the walker and stood from her wheelchair and walked into the bathroom with NA-A holding onto the gait belt. R1 walked back out of the bathroom with the walker and appeared to be steady with NA-A holding the gait belt, R1 pivoted and sat back down in her wheelchair.<br><br>On 8/21/25 at 1:46 p.m., NA-B was observed to assist R1 in her wheelchair back to her room. R1 appeared to be tearful and upset related to her family leaving her, but NA-B offered reassurance. NA-B exited R1's room and returned with the non-mechanical sit to stand lift. NA-B moved R1's wheelchair pedals off to the sit and positioned the lift in front of R1. R1 placed her feet on the platform, NA-B locks wheelchair brakes as well as the lift brakes and directs R1 to grab onto the bars and stand up. R1 follows all ques and stands up, and | 20565 | | |

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| 20565 | Continued from page 7<br>NA-B places the two paddles behind R1's bottom, unlocks lift brakes and brings R1 into the bathroom. NA-B then maneuvered R1 out of the bathroom in the lift and opens the lift legs over R1's wheelchair, locks the lift brakes and directs R1 to stand, paddles are removed and R1 sits down in her wheelchair.<br><br>On 8/21/25 at 2:06 p.m., R1 was sitting in her wheelchair in her room and stated she was able to walk "just fine" to and from the bathroom with a cane, but R1 was unsure why the staff were using a lift instead. R1 stated "I am afraid to ask they would tell me something I don't want to hear".<br><br>On 8/21/25 at 2:25 p.m. NA-B stated all NA's have access to each resident's care plan which would identify what each resident's transfer status and ADL assistance was. If there were changes to a resident's care plan the changes were communicated through verbal report at change of shift. Further, NA-B stated R1 required a non-mechanical sit to stand lift "always" and R1 was able to ambulate with a walker and a gait belt.<br><br>On 8/21/25 at 2:59 p.m., NA-C stated R1 required staff assistance with all ADLs and transferred with a non-mechanical sit to stand lift. NA-C stated R1 was not able to ambulate that she was aware of.<br><br>On 8/21/25 at 3:15 p.m., RN-C staff were expected to review the communication board in the facility's electronic medical record (EMR) system for changes and updates to a resident's care plan, however RN-C stated she was made aware recently some staff were not aware of how to do it so RN-C changed the process as of 8/21/25, and will now have a binder to communicate updates. Further, RN-C stated R1 was able to stand and pivot with assist of one staff to transfer using a gait belt and was able to ambulate with a cane. RN-C was not aware staff were utilizing a non-mechanical sit to stand lift to transfer R1 and no staff had reported any concerns or changes with R1's transfers. RN-C stated R1's transfer status was revised on 8/9/25. In addition, RN-C stated staff would be expected to report any changes or concerns and if a resident refuses staff should be documenting.<br><br>On 8/22/25 at 8:56 a.m., director of nursing (DON) stated R1's care plan was recently revised to ambulate R1 to and from the bathroom with assist of one staff and R1 was a stand and pivot transfer. DON stated staff were expected to report changes or concerns with a resident's transfer status to the case managers on the | 20565 | | |

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| 20565 | Continued from page 8<br>unit so the team was aware and could revise the care plan. Further, DON stated all staff would be expected to carry the electronic tablets and reference each resident's plan of care they are assisting.<br><br>A copy of the facility's care plan policy was requested but facility failed to provide.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 20565 | | |

| 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 08/22/2025 |
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| F0000 | INITIAL COMMENTS<br><br>On 8/20/25 through 8/22/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed. H53992560 (2591888) with a deficiency issued at F656.<br><br>As a result of the investigation, additional deficiencies were cited at F580 and F740.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F0000 | | 09/11/2025 |
| F0580<br>SS = D | Notify of Changes (Injury/Decline/Room, etc.)<br><br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br><br>(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-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a | F0580 | F580- Notify of Changes<br><br>R1's physician and representative have been notified of R1's skin tear. Re-education was completed with RN-D to ensure that with any skin incident identified and initiated, the resident's physician and representative are notified at that time.<br><br>All residents with skin injuries have the potential to be affected by this deficient practice.<br><br>All incidents have been reviewed to ensure documentation that the resident's physicians and the resident's representatives have been notified for the last 30 days.<br><br>The Accident/Incident Policy was reviewed with no | 09/22/2025 |

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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| 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 08/22/2025 |
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| F0580 SS = D | Continued from page 1<br>deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>(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<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(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.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident<br><br>representative(s).<br><br>§483.10(g)(15)<br><br>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).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review, the facility failed to notify physician and resident representative timely of a new injury for 1 of 3 residents (R1) reviewed.<br><br>Findings include: | F0580 | Continued from page 1<br>revisions needed. All nursing staff will be re-educated on this policy and process for updating the physician and resident representative timely upon finding any skin concerns.<br><br>A Notification of Skin Incident Audit will be completed on all incidents for 30 days. The DON will oversee the findings of the audits. The findings will be reviewed at QAPI with further recommendations and monitoring. | |

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| F0580 SS = D | Continued from page 2 | F0580 | | |

R1's quarterly Minimal Data Set (MDS) dated 5/27/25, indicated R1 had diagnoses which included traumatic subdural hemorrhage, cerebral infarction, anxiety disorder, and had severely impaired cognition.

R1's skin incident report dated 8/10/25, revealed registered nurse (RN)-D was called into R1's room to assess a skin tear to left front of lower shin. Staff had explained that they were getting R1 up and ready for the day and she pulled her pants down to change them. Upon lowering her pants, staff noticed that there was blood on the sheet and when she looked where it was coming from, staff observed a skin tear. RN-D completed wound care by cleaning and covering with bandage. R1 denied any pain in the area, but upon completing wound care R1 was seen wincing in pain. Both RN-D and staff assisted by applying Tubi grips to both lower extremities and proceeded to continue cares. Injuries observed at the time of the incident was a skin tear to left lower leg, RN-D cleansed wound with wound cleanser, skin flap was approximated with Q-Tip and covered with non-adherent pad, leg was then wrapped with rolled gauze and secured with tape, Tubi-grip placed over leg to hold dressing in place. Further incident report revealed R1's physician was notified on 8/12/25 at 2:05 p.m., and there was no evidence of resident representative being notified.

R1's progress note dated 8/10/25 at 9:23 p.m., R1's left leg skin tear dressing was removed by a nursing assistant because R1's daughter wanted to look at the wound. R1's record lacked evidence of R1's representative being notified prior and notification to resident's physician.

On 8/20/25 at 12:16 p.m., R1's resident representative (RR) stated she was at the facility on 8/09/25, and when she came to the facility on 8/10/25, RR stated she inquired to staff about a bruise on her arm and that was when the staff notified her of the skin tear on R1's leg. RR stated typically she would receive a phone call from the staff on incidents, but she was not notified of the skin tear until later in the day.

On 8/20/25 at 3:52 p.m., RN-A stated staff were expected to notify provider and family as soon as staff were aware of any new skin impairments.

On 8/20/25 at 9:25 a.m., licensed practical nurse (LPN)-A stated new injuries or skin impairments were expected to be reported to the charge nurse and they would complete an incident report and inform the unit case managers and director of nursing (DON), and the

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| F0580 SS = D | Continued from page 3<br>DON would notify the physician and family as soon as the DON was made aware.<br><br>On 8/21/25 at 10:08 a.m., RN-B stated new skin impairments were expected to be reported to the physician and family immediately or within your shift depending on severity. The floor nurse would be expected to complete an incident report and part of the incident report would be notifications to appropriate parties such as physician, family and DON.<br><br>On 8/21/25 at 3:15 p.m., RN-C stated for new skin impairments, the floor nurse was expected to complete a risk management (incident report), provide aid and treatment to the injury, notify DON and nurse on call. Further, RN-C stated the physician, and resident representative would be expected to be notified immediately as well.<br><br>On 8/21/25 at 4:40 p.m., attempted interview with R1's provider was unsuccessful.<br><br>On 8/22/25 at 8:56 a.m., DON stated staff were expected to complete an incident report upon discovering a new skin impairment, and part of the document required staff to notify the physician and resident representative. DON stated RN-D discovered the skin tear in the early morning of 8/10/25 and passed on in report to the next shift because RN-D was unable to complete all tasks due to having a busy night. DON stated RR was upset she was not notified.<br><br>On 8/22/25 at 9:59 a.m., RN-D stated at approximately 5:30 a.m. on 8/10/25, RN-D was paged to go to R1's room and RN-D observed the skin tear. RN-D stated she assessed the wound and passed through report to the next shift of the update. RN-D stated she was not completed with her charting at 6:30 a.m. when her shift was over, so RN-D returned to the facility later that afternoon to complete the incident report. RN-D stated she was aware she did not notify R1's resident representative and "I am sure [RR] was not happy", and RN-D confirmed she did not notify R1's physician because, "it all happened so fast". Further, RN-D stated notifying the physician and resident representative was part of completing the incident report, and staff were expected to call nurse triage and leave a message for the resident's physician and notify the resident's representative.<br><br>On 8/26/25 at 11:30 a.m., return call from RN-E, nurse at R1's physician's office, RN-E confirmed the provider was not notified of R1's skin tear until a note was received from the facility a couple days later about a | F0580 | | |

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| F0580 SS = D | Continued from page 4<br>wound dressing.<br><br>A copy of the facility's notification policy was requested but facility failed to provide. | F0580 | | |
| F0656 SS = D | Develop/Implement Comprehensive Care Plan<br><br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§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 -<br><br>(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<br><br>(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).<br><br>(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.<br><br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(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.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. | F0656 | F656- Develop/Implement Comprehensive Care Plan<br><br>R1's Care Plan was updated to reflect current interventions for transfers.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>All residents' care plan interventions for transfers have been reviewed by the Case Managers to ensure they reflect the residents' current transfer safety needs.<br><br>RN Case Managers have been educated that the Care Plan flows to the Kardex, which is the tool that the CNAs utilize to know the resident's current plan of care and safety interventions. Paper binders with residents' plan of care will not be utilized on the units.<br><br>The policy, Person Centered Care Plan, was reviewed with no revisions needed. Nurse Managers have been re-educated on the policy.<br><br>All nursing staff will be re-educated on the EHR in PointClick Care. They will be re-educated on where to access the Care Plan and Kardex (tool for how to care for the resident) on the IPads and computers provided for them on each unit.<br><br>A Transfer Care Plan Audit will be completed 3x/week for 3 weeks, 2x/week for 2 weeks, and weekly for 3 weeks. The DON will oversee the findings of the audits. The findings will be reviewed at QAPI for further recommendations and monitoring. | 09/22/2025 |

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| F0656 SS = D | Continued from page 5<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and document review, the facility failed to ensure care plan interventions for transfers were implemented for 1 of 3 residents (R1) reviewed.<br><br>Findings include:<br><br>R1's quarterly Minimal Data Set (MDS) dated 5/27/25, indicated R1 had diagnoses which included traumatic subdural hemorrhage, cerebral infarction, anxiety disorder, and R1 had severely impaired cognition.<br><br>R1's care plan revised on 8/9/25, identified R1 had an activities of daily living (ADL) self- care deficit related to confusion due to recent stroke and staff were direct to ambulate R1 to meals as able with a single quad cane, gait belt, and contact guard assist, recommend another staff to follow with wheelchair and the nurse would document all attempts that fail. R1's care plan also directed staff to ambulate R1 to and from the bathroom with assist of one and a single quad cane, gait belt, and contact guard assist, recommend another staff to follow with wheelchair and nurse to document all attempts that fail.<br><br>R1's Progress Note dated 8/20/25, revealed no change in condition noted this shift. R1 required extensive assist of one with the non-mechanical sit to stand lift and R1 did not exhibit any behaviors. R1's record lacked evidence of any failed attempts related to transfers or ambulation.<br><br>On 8/20/25 at 12:16 p.m., anonymous reporter (AR) stated R1 received outpatient therapy and R1 was provided with orders for facility staff to assist R1 with ambulating to and from the bathroom with a cane, as well as to and from meals as tolerated. AR stated the facility were not following R1's care plan and had been transferring R1 using a non-mechanical stand lift.<br><br>On 8/20/25 at 3:52 p.m., registered nurse (RN)-A stated R1 required assistance by staff for all activities of daily living (ADL), and R1's care plan at this time identified R1 required assistance by one staff member | F0656 | | |

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| F0656 SS = D | Continued from page 6<br>for stand and pivot transfers and utilizing a cane for ambulation. Further, RN-A stated at times R1 would be weaker and require more staff assistance with transfers and the use of a non-mechanical stand lift.<br><br>On 8/21/25 at 9:25 a.m. licensed practical nurse (LPN)-A stated R1 required assistance with all ADLs and required a non-mechanical sit to stand lift for transfers and depending on the day was able to stand and pivot but was unable to ambulate.<br><br>On 8/21/25 at 10:08 a.m., RN-B stated R1 was not resistive to cares and was usually easy to talk through tasks and allow staff to assist with tasks. RN-A stated R1 required a non-mechanical sit to stand lift for transfers assistance by one staff, and RN-A stated she had not witnessed R1 ambulate at the facility but R1 was able to ambulate in therapy.<br><br>On 8/22/25 at 12:00 p.m., nursing assistant (NA) stated R1 recently received new therapy orders directing staff to assist with ambulating to and from the restroom with a cane and gait belt. NA-A stated R1 often chooses which staff she prefers to ambulate for and if R1 was not compliant staff would often use the non-mechanical sit to stand lift to transfer.<br><br>On 8/21/25 at 12:15 p.m., NA-A was observed assisting R1 in her wheelchair to R1's room. NA-A asked R1 if she was able to walk to the bathroom and R1 stated "yes", so NA-A placed a gait belt around R1's waist and R1 stated she wanted to use her walker instead of the cane. R1 placed hands on the walker and stood from her wheelchair and walked into the bathroom with NA-A holding onto the gait belt. R1 walked back out of the bathroom with the walker and appeared to be steady with NA-A holding the gait belt, R1 pivoted and sat back down in her wheelchair.<br><br>On 8/21/25 at 1:46 p.m., NA-B was observed to assist R1 in her wheelchair back to her room. R1 appeared to be tearful and upset related to her family leaving her, but NA-B offered reassurance. NA-B exited R1's room and returned with the non-mechanical sit to stand lift. NA-B moved R1's wheelchair pedals off to the sit and positioned the lift in front of R1. R1 placed her feet on the platform, NA-B locks wheelchair brakes as well as the lift brakes and directs R1 to grab onto the bars and stand up. R1 follows all ques and stands up, and | F0656 | | |

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| F0656 SS = D | Continued from page 7<br>NA-B places the two paddles behind R1's bottom, unlocks lift brakes and brings R1 into the bathroom. NA-B then maneuvered R1 out of the bathroom in the lift and opens the lift legs over R1's wheelchair, locks the lift brakes and directs R1 to stand, paddles are removed and R1 sits down in her wheelchair.<br><br>On 8/21/25 at 2:06 p.m., R1 was sitting in her wheelchair in her room and stated she was able to walk "just fine" to and from the bathroom with a cane, but R1 was unsure why the staff were using a lift instead. R1 stated "I am afraid to ask they would tell me something I don't want to hear".<br><br>On 8/21/25 at 2:25 p.m. NA-B stated all NA's have access to each resident's care plan which would identify what each resident's transfer status and ADL assistance was. If there were changes to a resident's care plan the changes were communicated through verbal report at change of shift. Further, NA-B stated R1 required a non-mechanical sit to stand lift "always" and R1 was able to ambulate with a walker and a gait belt.<br><br>On 8/21/25 at 2:59 p.m., NA-C stated R1 required staff assistance with all ADLs and transferred with a non-mechanical sit to stand lift. NA-C stated R1 was not able to ambulate that she was aware of.<br><br>On 8/21/25 at 3:15 p.m., RN-C staff were expected to review the communication board in the facility's electronic medical record (EMR) system for changes and updates to a resident's care plan, however RN-C stated she was made aware recently some staff were not aware of how to do it so RN-C changed the process as of 8/21/25, and will now have a binder to communicate updates. Further, RN-C stated R1 was able to stand and pivot with assist of one staff to transfer using a gait belt and was able to ambulate with a cane. RN-C was not aware staff were utilizing a non-mechanical sit to stand lift to transfer R1 and no staff had reported any concerns or changes with R1's transfers. RN-C stated R1's transfer status was revised on 8/9/25. In addition, RN-C stated staff would be expected to report any changes or concerns and if a resident refuses staff should be documenting.<br><br>On 8/22/25 at 8:56 a.m., director of nursing (DON) stated R1's care plan was recently revised to ambulate | F0656 | | |

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| F0656 SS = D | Continued from page 8<br>R1 to and from the bathroom with assist of one staff and R1 was a stand and pivot transfer. DON stated staff were expected to report changes or concerns with a resident's transfer status to the case managers on the unit so the team was aware and could revise the care plan. Further, DON stated all staff would be expected to carry the electronic tablets and reference each resident's plan of care they are assisting.<br><br>A copy of the facility's care plan policy was requested but facility failed to provide. | F0656 | | |
| F0740 SS = D | Behavioral Health Services<br><br>CFR(s): 483.40<br><br>§483.40 Behavioral health services.<br><br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and document review, the facility failed to monitor, review, and analyze underlying causes of resident's anxiety and agitation for 1 of 1 resident (R1) who was reviewed for behaviors.<br><br>Findings include:<br><br>R1's quarterly Minimal Data Set (MDS) dated 5/27/25, indicated R1 had diagnoses which included traumatic subdural hemorrhage, cerebral infarction, anxiety disorder, and R1 had severely impaired cognition and R1 did not exhibit any behaviors.<br><br>R1's medication administration record (MAR) and treatment administration record (TAR) for the month of August 2025, revealed R1 was prescribed Trazodone 100 mg at bedtime for insomnia. TAR lacked evidence of target behaviors being monitored.<br><br>R1's Psychoactive Medication Informed Consent Form dated 3/19/25, revealed R1 was prescribed Trazodone, but the document lacked reason for use (target | F0740 | F740- Behavioral Health Services<br><br>R1 has had a behavior review of her anxiety and agitation. This includes revising the interventions in place, a monitoring process, and a review of underlying causes.<br><br>All residents who take psychotropic medications have the potential to be affected by this deficient practice.<br><br>A review of all residents on psychotropic medication was completed to ensure that they have written consents completed, target behaviors identified, and non-pharmacological interventions in place.<br><br>The Psychotropic Medications Policy was reviewed with no revisions needed.<br><br>All staff were educated on symptoms of anxiety and agitation that they may observe during their shifts, and that this should be reported to a nurse on the unit. All nursing staff will be re-educated on target behaviors and non-pharmacological interventions that are person-centered for residents. They will be re-educated on where to locate this information and how to document interventions tried and whether they were successful or not. Nurse Managers were re-educated on the Psychotropic Medications Policy and Process to ensure the residents' care plans have this information identified and available to staff.<br><br>A Psychotropic Medication Audit will be completed 3x/week for 3 weeks, 2x/week for 2 weeks, and weekly for 3 weeks. The DON will oversee the findings of the audits. The findings will be reviewed at QAPI for further recommendations and monitoring. | 09/22/2025 |

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| F0740 SS = D | Continued from page 9<br>behaviors) of this psychoactive medication, non-pharmacological interventions, or benefits to be obtained in using this medication.<br><br>R1's care plan as of 8/20/25, indicated R1 had impaired cognitive function and impaired thought processes related to disease process and recent stroke. R1 was also noted to have a communication problem related to expressive aphasia and receptive aphasia. R1 was at risk for falls related to confusion, gait/balance problems, psychoactive drug use, unaware of safety needs and directed staff to check for urinary tract infection with increased restlessness and confusion, and when restless at night offer a snack and something to drink. Further, R1's care plan identified R1 had difficulty with sleep and directed staff to administer any medications per provider order, monitor for side effects and effectiveness, offer a snack of pudding/toast for nighttime restlessness, discourage a pattern of daytime naps, and encourage R1 to follow a consistent routine retiring and arising.<br><br>R1's Progress Notes revealed the following:<br><br>-On 8/19/25, moved the trash bin she was running into and tried to move her to a more open area however continued to run into things.<br><br>-On 8/19/25, minimal sleep this shift from 0100-0300. Restlessness and wandering remain evident throughout the pod, attempted to enter other resident's rooms as well as other rooms on the floor (shower room, clean utility room and dirt utility room).<br><br>-On 8/18/25, resident has been wheeling self-backwards at an extensive rate of speed. Due to impairments of ability to see when wheeling backwards, resident then runs into items aggressively (walls, lifts, other residents, etc.) Resident was witnessed to have run into another resident his shift while this resident was sitting out on the pod. Resident had run into the back of the wheelchair and no injuries were sustained but when redirected, the behaviors did not change.<br><br>-On 8/18/25, resident wandered into another resident's room who was sleeping, entered the room and began to attempt to rove their walker, thus resulting in this resident becoming entangled in the walker, nearly causing them to fall. Resident was redirected back to the center of the pod but wandering remains present as well as discussions toward other confused residents, stating "you stay over there and stay away from me or else". | F0740 | | |

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| F0740 SS = D | Continued from page 10<br><br>-On 8/18/25, resident completely unconsolable this shift regardless of attempts from staff or other residents. Yelling out “help”, “get him away from me”. Resident crying uncontrollably to the extent that she was unable to catch her breathe. Behaviors only subside when resident was on a one to one with another staff member. There are no PRN (as needed medication) available to assist with increased anxiety and restlessness.<br><br>-On 8/15/25, resident was wheeling herself backwards and yelling help repeatedly and trying to go into other people’s rooms. Staff tried to offer a snack, which she did not want. Tried offering resident to watch a show on the tablet, which was not effective. When asking resident what her need was, she would say “I don’t need anything”. No pharmacological interventions available currently.<br><br>-On 8/11/25, R1 was yelling at staff to get out of here, “you need to die” and “I’m going to kill you”. R1 had been exhibiting behaviors since 2:00 p.m. Distraction, food, drink and toileting were not effective. There were no pharmacological intervention to give her. Daughter came in at about 6:30 p.m. took her outside and when daughter brought her back in the yelling started all over again.<br><br>-On 8/9/25, resident was heard yelling at another resident on the pod. Staff tried to redirect resident away and continued to yell inappropriate words at another resident. Resident was then brough down to other wing to completely change surroundings and resident continued to yell out obscenities and inappropriate comments to nurse and staff on that side. Non-pharmacological interventions attempted included one to one staff involvement, took for ride in wheelchair around inside of the building, offered snack and drink which were not effective.<br><br>-On 7/24/25, resident was weeping and crying and stated, “I might as well be dead”. One to one distraction did not seem to be effective, and resident would continue to have weeping episodes.<br><br>-On 7/19/25, resident was yelling out for help, thinks resident was trying to kill us thinking she had to clean something up. Distraction, toileting and one to one with the nurse was attempted but was not effective.<br><br>-On 7/17/25, resident was wheeling into other rooms yelling at others saying, “I’m going to kill you, I have the power”. Staff separated then resident was | F0740 | | |

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| F0740 SS = D | Continued from page 11<br>calling multiple staff killers and that she had all the power.<br><br>-On 7/16/25, Resident awoke at 0300 yelling out from her room. Resident yelling “get her out of here or I will”, then began making threats to nursing assistant of hilling staff if she wasn’t removed. Resident was unconsolable at that time. Distraction was unsuccessful with the use of TV show, food/beverage, etc.<br><br>-On 7/11/25, resident was roaming the pod aimlessly searching for random items such as the “sewer” stating, “I’m going to blow it up. I have a finger that will do it.” Behavior was unable to be redirected. Resident continued to push herself backwards in her wheelchair throughout the hallway and pods, talking nonsensical statements to self and others as they walked by.<br><br>On 8/20/25 at 3:52 p.m., registered nurse (RN)-A stated R1 exhibited behaviors of yelling and “ramming around in here”, and R1 would often resist cares such as toileting especially at night. RN-A stated staff would attempt to offer distraction of coloring, drink, food, bathroom, one to one staffing but there were only so much non-pharmacological interventions that are effective.<br><br>On 8/21/25 at 12:00 p.m., nursing assistant (NA)-A stated R1 exhibited behaviors such as yelling, swatting at staff, crying, and will self-propel around the unit with no sense of direction and would run into things.<br><br>On 8/21/25 at 1:46 p.m., R1 was observed to be tearful and stating her daughter did not care about her, and NA-B would offer reassurance and offered toileting. Interventions were only effective a short while, and NA-B was observed to be tearful again.<br><br>On 8/21/25 at 2:25 p.m., NA-B stated R1’s cognition was impaired and R1 had some forgetfulness and confusion. NA-B stated later afternoon/evenings R1 would often get anxious and agitated and would cuss out staff or have some delusions about a shooter and interventions of distraction was often not effective. Further, NA-B stated these behaviors were R1’s baseline and the behaviors appeared to be “constant”.<br><br>On 8/21/25 at 2:59 p.m., NA-C stated R1 exhibited behaviors through out the night such as hollering, attempting to go into other resident’s rooms and staff would offer snack, warm towels, sit with R1, read her a magazine to attempt to calm R1 and these behaviors have been R1’s baseline since NA-C started working at the facility. | F0740 | | |

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| F0740 SS = D | Continued from page 12<br><br>On 8/21/25 at 3:15 p.m., RN-C stated R1 exhibited behaviors of hollering, verbal combativeness with staff and threatening to “kill you”. RN-C stated these behaviors have been R1’s baseline and typically occur in the evenings, but at times do increase in frequency with an infection. RN-C stated staff are expected to chart resident behaviors in the resident treatment record and resident care plan would be expected to reflect target behaviors to monitor as well as person-centered interventions to implement. RN-C confirmed there were no target behaviors listed in R1’s care plan and there was no treatment order for staff to monitor or document R1’s behaviors to review for psychotropic medication effectiveness, which R1 was prescribed Trazodone.<br><br>On 8/22/25 at 8:56 a.m., director of nursing (DON) stated R1 had exhibited behaviors since admitting to the facility, but the behaviors appeared to increase when there was an infection. DON stated staff were expected to monitor effectiveness of psychotropic medications and track behaviors. Each resident would be expected to have target behaviors in their treatment record for staff to document as well as in the resident care plan with interventions for staff to implement if a resident was exhibiting behaviors.<br><br>A copy of the facility’s behavior and psychotropic medication policy was requested but facility failed to provide. | F0740 | | |