DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 6, 2026

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

RE: CCN:245399
Cycle Start Date: April 20, 2026

Dear Administrator:

On April 20, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 20, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 20, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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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May 6, 2026

Administrator
Little Falls Care Center
1200 FIRST AVENUE NORTHEAST
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Re: State Nursing Home Licensing Orders
Event ID: 22EABC-H1

Dear Administrator:

The above facility survey was completed on April 20, 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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: 245399	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/20/2026

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
F0000	INITIAL COMMENTS On 4/16/26 and 4/20/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53992780C (2706175) with citation issued at F689. 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.	F0000		05/06/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to complete comprehensively assess level of supervision and failed to complete root cause analysis (RCA) following falls for 1 of 3 residents (R1) reviewed for falls. Findings include R1’s psychiatric mental health evaluation summary	F0689	0830 Corrected 1. Corrective Action for Resident(s) Affected R1 experienced falls without timely comprehensive post-fall assessment, root cause analysis, and individualized supervision interventions. Comprehensive post-fall assessments and root cause analyses were completed for R1 on 4/20/26 and 5/14/26, including: Detailed review of fall circumstances (location, time, activity) Resident-specific risk factors (cognition, impulsivity, mobility limitations, behaviors, medications) Environmental factors (lighting, clutter, equipment use)	05/27/2026

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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F0689 SS = D	Continued from page 1 note dated 2/25/26, indicated R1's diagnoses included major neurocognitive disorder due to vascular disease, with behavioral disturbance, severe, abnormalities of gait and mobility, repeated falls, cerebral vascular disease (CVA) with left hemiparesis, acute encephalopathy, and chronic pain. R1's comprehensive quarterly Minimum Data Set (MDS) dated 3/3/26, indicated R1 had severe cognitive impairment and required substantial/maximal assistance for toileting, transfers, lying to sitting on bed side, and put on/take off footwear. R1's activities of daily living (ADLs) care plan dated 2/19/25 revised on 3/1/26, indicated R1 required assistance of two with stand assist utilize full mechanical lift as needed for weakness or fatigue for transfers. R1's ADLs care plan dated 2/19/25 revised 8/28/25, directed staff to turn and reposition R1 in bed every 2-3 hours and as necessary. R1's ADLs care plan dated 8/22/25, directed staff to analyze time of day, places, circumstances, triggers, and what de-escalates behavior and document these findings. Additionally, R1's ADLs care plan dated 8/22/25 directed staff to assess and anticipate R1's toileting needs, comfort level, body positioning, pain etc. Despite these directives, the care plan did not include enhanced supervision or incorporate the psychiatric evaluation's recommendation for 24-hour supervision, completed on 2/25/26. R1's psychiatric mental health evaluation dated 2/25/26, recommended R1 required 24-hour supervision to ensure safety. The evaluation further indicated simple ADLs needed to be initiated by caregiver and continual supervision may be needed to correct R1's behaviors. R1's medical record review from February and March 2026 showed no adequate documented analysis of root causes, no evidence that the interdisciplinary team revised the care plan, and no documentation that R1's supervision needs were reassessed according to the psychiatric evaluation. R1's progress note dated 2/18/26 at 8:25 p.m., indicated R1 had an unwitnessed fall in the lounge area next to brick wall when her wheelchair (WC) had stuck in a curve of the wall. The note further indicated R1 slipped out of WC landing on pedals with her knees bent under her. Staff assisted R1 straighten legs out and then used a full mechanical lift to transfer R1 back into her WC. The root cause analysis was not identified but the corresponding	F0689	Continued from page 1 Staff response and supervision level at time of fall The interdisciplinary team (IDT) (nursing, therapy, social services, provider as indicated) reviewed findings. The care plan will be revised immediately to include individualized supervision and monitoring interventions, specifying: Level of supervision Frequency High-risk situations 2. Identification of Other Residents at Risk All residents with falls from 4/1/26 have the potential to be affected. A 100% audit will be completed for: All residents with any fall since 4/1/26 All residents with ≥2 falls will receive priority review Each record will be reviewed for: Timeliness (within 24-48 hours) of post-fall assessment and root cause analysis Identification of contributing factors Individualized supervision interventions Care plan updates reflecting findings Deficiencies identified will be corrected immediately.	05/27/2026

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F0689 SS = D	Continued from page 2 interventions identified as staff were to ensure R1 had been toileted every two hours, change and reposition, bed in lower position, and call light within reach. R1's progress note dated 2/25/26 at 9:14 p.m., indicated R1 experienced an unwitnessed fall in the hallway. Staff reported R1 had been pushing herself around the pod in an attempt to leave the building and was found sitting on the pedals of her WC. No injuries were noted. The root cause analysis identified R1 had slipped out of her WC due to the right foot pedal being in the down position. R1 used only one foot pedal because she propelled herself with her other foot, which increased the likelihood of sliding forward when the unused pedal remained attached. The corresponding intervention was to remove the right foot pedal, label it, and store it in the closet for use only during medical appointments. R1's progress note dated 3/4/26 at 10:59 p.m., indicated R1 had unwitnessed fall in her room with no injuries. The note lacked evidence of the root cause analysis for the fall. The note lacked the root cause analysis for the fall. R1's progress note dated 3/16/26 at 6:40 a.m., indicated R1 had unwitnessed fall in her room where she was found laying partially on the floor and partially on the fall mat next to her bed. The note further indicated R1 was found on the floor by another resident. Upon assessment, R1 did not sustain any injuries but staff were unable to rule out head strike and staff used mechanical lift to transfer R1 from the floor back to bed. However, the progress note did not include evidence of a root cause analysis (RCA) for the fall. R1's progress note dated 3/17/26 at 00: 30 a.m., indicated R1 had unwitnessed fall on 3/16/26 at 8:30 p.m. Staff found R1 lying on her floor mat with her bedding wrapped around her lower extremities. No injuries were noted. The note lacked evidence of the root cause analysis for the fall. Staff documented they have requested the provider to reconcile R1's medications to promote improved sleep patterns; however, this intervention alone did not substitute for a comprehensive RCA to determine why the fall occurred or how to prevent recurrence. R1's progress note dated 3/18/26 at 00:17 a.m., indicated R1 experienced unwitnessed fall on 3/17/26 at 10:10 p.m. Staff found R1 lying next to her bed, partially on the fall mat and partially on the floor, positioned on her left side. Her brief on the bed, and she was incontinent of urine. R1 did not	F0689	Continued from page 2 3. Systemic Changes / How Deficient Practice Will Be Corrected A. Standardized Post-Fall Process (REQUIRED AFTER EVERY FALL) Licensed nursing staff will complete a comprehensive post-fall assessment within 24-48 hours of each fall that includes: Immediate assessment (at time of fall) Structured root cause analysis including: Intrinsic factors (cognition, behavior, medications, functional decline) Extrinsic factors (environment, equipment, staffing/supervision gaps) Time-of-day and activity patterns IDT review within 72 hours (or sooner if high risk) B. Individualization of Supervision & Monitoring (NEW CLARIFICATION) Supervision/monitoring interventions will be determined and individualized based on assessment findings. C. Care Plan Requirements Following each fall: Care plan updated within 24 hours of assessment completion Must include: Specific supervision level High-risk times/situations	05/27/2026

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F0689 SS = D	Continued from page 3 sustain any visible injuries and transferred back to bed using a full mechanical lift. The note lacked evidence of the RCA. R1's treatment administration record dated March 2026, indicated R1 had a fall on 3/29/26 at 1:00 p.m. with no injury. R1's record did not include a comprehensive root cause analysis. = R1 experienced seven unwitnessed falls between 2/25/26 and 3/17/26. During this period, R1's psychiatric mental health evaluation identified a need for continuous supervision, yet across these events, the facility's documentation showed inconsistent completion of root cause analyses and limited evidence of comprehensive evaluation of contributing factors as directed by R1's care plan. Despite these recommendations, the facility did not consistently assess or address the factors contributing to R1's repeated falls, the care plan was not updated to reflect the psychiatric recommendation for enhanced supervision. During an interview on 4/20/26 at 5:23 p.m., a family member (FM)-A stated she was not always informed about R1's fall incidents. FM-A reported R1 should be toileting every two hours while awake but this was not happening, especially when agency staff were working. FM-A explained staff did not pay attention to R1's needs, which my increase her behavior resulting in falls. FM-A stated she came to visit R1 on 4/18/26 and she was incontinent with urine, her WC was wet and smelling. R1 was sitting alone in the pod, and she had to call an NA to help R1. FM-A stated she did not report the incident to the nurse manager because they would not do anything to address the issue as always. During an interview on 4/20/26 at 1:03 p.m., a nursing assistant (NA)- A stated R1 "tries to get up without help a lot" and "we don't always have someone right there to watch her." NA-A explained she had been walking in the hallway past R1's room when she observed R1 lying on the floor next to her bed, partially on the fall mat, on 3/17/26. NA-A stated R1's brief was on the bed, and R1 was incontinent of urine at the time. NA-A stated she immediately notified the nurse, who came to assess R1 before R1 was transferred back to bed using a mechanical lift. NA-A stated she was not aware of any new interventions added after R1's repeated falls. During an interview on 4/20/26 at 1:48 p.m., NA-B stated R1 had experienced multiple falls in her room and R1 needed to be checked every two hours to	F0689	Continued from page 3 Interventions tied directly to identified root causes 4. Education and Staff Accountability Education Provided To: Licensed nurses Nurse leadership Direct care staff (CNAs/TMAs) Interdisciplinary team (therapy, social services, providers, activities) Education Content Includes: Post-fall assessment timelines and requirements Root cause analysis process Determining and implementing individualized supervision Staff responsibility for: Monitoring compliance Reporting changes in condition Implementing fall interventions Expectations for real-time response after falls Accountability Measures: Direct observation of staff performing:	05/27/2026

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F0689 SS = D	Continued from page 4 prevent further falls. NA-B reported R1 might be highly sensible to environmental factors such as noise, loud music, or light which could contribute to her repeated fall incidents. NA-B stated she did not recall any team discussions on the unit regarding R1's multiple falls or strategies to prevent recurrence. NA-B explained they were not aware of any new interventions added following R1's repeated falls. During an interview on 4/20/26 at 2:49 p.m., a licensed practical nurse (LPN)-A who served as R1's case manager stated R1 was "one of the frequent fallers" and she was aware of her multiple fall incidents. LPN-A reported she did not provide any education to the staff regarding R1's repeated falls or the corresponding interventions needed to ensure R1's safety. LPN-A stated she was not sure who updated R1's care plan following the falls. LPN-A reported she was unaware of R1's psychiatric mental health evaluation dated 2/25/26, which recommended 24-hour supervision to ensure R1's safety. LPN-A confirmed that supervision levels were not increased despite R1's ongoing fall pattern. During an interview on 4/20/26 at 3:46 p.m., a registered nurse RN-A stated R1 "had been falling a lot lately," but the care plan "hadn't really changed." RN-A reported she completed the post fall evaluation on 2/26/26 for R1's unwitnessed fall on 2/18/26, during which R1's WC became stuck in a curve of the wall and R1 slipped out of WC, landing on pedals. RN-A stated she did not know what was decided during the interdisciplinary meeting regarding R1's falls. RN-A also reported she was unable to locate documentation in R1's medical record indicating whether a comprehensive assessment had been completed to guide an effective plan to prevent further falls. RN-A reported she was unaware of R1's psychiatric mental health evaluation dated 2/25/26, which recommended 24-hour supervision to ensure R1's safety. RA-A confirmed that supervision levels were not increased despite R1's ongoing fall pattern. During an interview on 4/20/26 at 4:16 p.m., the director of nursing (DON) stated R1 was a frequent faller, and the facility had been trying to work with FM-A to determine what interventions might work better for R1. The DON stated she did not know whether each fall had been reviewed to identify the root cause analysis with corresponding interventions to prevent recurrence. The DON stated she expected staff to complete a comprehensive assessment after multiple falls to determine to the root cause;	F0689	Continued from page 4 rounds Resident supervision per care plan Non-compliance will result in: Immediate re-education Progressive discipline if repeated 5. Monitoring and Quality Assurance The DON or designee will complete weekly audits for 12 weeks, then monthly as indicated. Audit Will Include BOTH Record Review AND Direct Observation: A. Record Review Post-fall assessment completed within 24 hours Root cause analysis completed and documented IDT involvement documented Care plan updated with individualized interventions Evidence that interventions address specific contributing factors B. Direct Observation Staff implementing required supervision levels (e.g., rounding frequency) Residents receiving assistance during high-risk activities (toileting/transfers) Environmental safety compliance (lighting, clutter, equipment use)	05/27/2026

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F0689 SS = D	Continued from page 5 however, she was unable to locate any comprehensive assessment in R1's medical record despite multiple falls. The DON reported she was unaware of R1's psychiatric mental health evaluation dated 2/25/26, which recommended 24-hour supervision to ensure R1's safety. The DON confirmed that supervision levels were not increased despite R1's ongoing fall pattern. The DON explained since R1's psychiatric mental health evaluation on 2/25/26, R1 had experienced seven fall incidents with no injuries. The DON confirmed staff did not update R1's care plan to reflect the psychiatric recommendations. The DON stated R1 should have had additional interventions added and that the facility "did not follow through". Fall Prevention and Management Policy dated 6/5/23 indicated the care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. The policy also directed staff to complete a falls analysis when a resident has two or more falls, to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. Additionally, the policy indicated the facility will educate staff, residents, and families to promote a culture of safety, to keep residents safe and reduce falls risks.	F0689	Continued from page 5 C. Staff Interviews Staff able to verbalize: Resident-specific fall risks Required supervision/interventions Performance Indicators: 100% compliance with: Timely post-fall assessments Root cause analysis completion Care plan updates with individualized interventions ≥95% compliance with staff implementation of interventions Follow-Up Actions: Any deficiency → immediate correction + staff re-education Trends analyzed weekly 6. QAPI & Sustainability Audit findings will be: Reviewed weekly in clinical meeting Reported at QAPI committee quarterly (or more frequently if indicated) QAPI will:	05/27/2026

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 04/20/2026

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F0689 SS = D		F0689	Continued from page 6 Trend fall patterns Evaluate effectiveness of interventions Recommend systemic changes Sustained compliance required before reducing audit frequency	05/27/2026

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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 4/16/26 and 4/20/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaint was reviewed: H53992780C (2706175) with licensing orders issued at 20830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and	20000		05/06/2026

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

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20000	Continued from page 1 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		05/06/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to complete comprehensively assess level of supervision and failed to complete root cause analysis (RCA) following falls for 1 of 3 residents (R1) reviewed for falls. Findings include R1’s psychiatric mental health evaluation summary note dated 2/25/26, indicated R1’s diagnoses included major neurocognitive disorder due to vascular disease, with behavioral disturbance, severe, abnormalities of gait and mobility, repeated falls, cerebral vascular disease (CVA) with left hemiparesis, acute encephalopathy, and chronic pain. R1’s comprehensive quarterly Minimum Data Set (MDS) dated 3/3/26, indicated R1 had severe cognitive impairment and required substantial/maximal assistance for toileting, transfers, lying to sitting on bed side, and put on/take off footwear. R1’s activities of daily living (ADLs) care plan dated 2/19/25 revised on 3/1/26, indicated R1 required assistance of two with stand assist utilize full mechanical lift as needed for weakness or fatigue for transfers. R1’s ADLs care plan dated 2/19/25 revised 8/28/25, directed staff to turn and reposition R1 in bed every 2-3 hours and as necessary. R1’s ADLs care plan dated 8/22/25, directed staff to analyze time of day, places, circumstances, triggers,	20830	Completed	05/27/2026

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20830	Continued from page 2 and what de-escalates behavior and document these findings. Additionally, R1's ADLs care plan dated 8/22/25 directed staff to assess and anticipate R1's toileting needs, comfort level, body positioning, pain etc. Despite these directives, the care plan did not include enhanced supervision or incorporate the psychiatric evaluation's recommendation for 24-hour supervision, completed on 2/25/26. R1's psychiatric mental health evaluation dated 2/25/26, recommended R1 required 24-hour supervision to ensure safety. The evaluation further indicated simple ADLs needed to be initiated by caregiver and continual supervision may be needed to correct R1's behaviors. R1's medical record review from February and March 2026 showed no adequate documented analysis of root causes, no evidence that the interdisciplinary team revised the care plan, and no documentation that R1's supervision needs were reassessed according to the psychiatric evaluation. R1's progress note dated 2/18/26 at 8:25 p.m., indicated R1 had an unwitnessed fall in the lounge area next to brick wall when her wheelchair (WC) had stuck in a curve of the wall. The note further indicated R1 slipped out of WC landing on pedals with her knees bent under her. Staff assisted R1 straighten legs out and then used a full mechanical lift to transfer R1 back into her WC. The root cause analysis was not identified but the corresponding interventions identified as staff were to ensure R1 had been toileted every two hours, change and reposition, bed in lower position, and call light within reach. R1's progress note dated 2/25/26 at 9:14 p.m., indicated R1 experienced an unwitnessed fall in the hallway. Staff reported R1 had been pushing herself around the pod in an attempt to leave the building and was found sitting on the pedals of her WC. No injuries were noted. The root cause analysis identified R1 had slipped out of her WC due to the right foot pedal being in the down position. R1 used only one foot pedal because she propelled herself with her other foot, which increased the likelihood of sliding forward when the unused pedal remained attached. The corresponding intervention was to remove the right foot pedal, label it, and store it in the closet for use only during medical appointments. R1's progress note dated 3/4/26 at 10:59 p.m., indicated R1 had unwitnessed fall in her room with no injuries. The note lacked evidence of the root cause analysis for the fall. The note lacked the root	20830		05/27/2026

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20830	Continued from page 3 cause analysis for the fall. R1's progress note dated 3/16/26 at 6:40 a.m., indicated R1 had unwitnessed fall in her room where she was found laying partially on the floor and partially on the fall mat next to her bed. The note further indicated R1 was found on the floor by another resident. Upon assessment, R1 did not sustain any injuries but staff were unable to rule out head strike and staff used mechanical lift to transfer R1 from the floor back to bed. However, the progress note did not include evidence of a root cause analysis (RCA) for the fall. R1's progress note dated 3/17/26 at 00: 30 a.m., indicated R1 had unwitnessed fall on 3/16/26 at 8:30 p.m. Staff found R1 lying on her floor mat with her bedding wrapped around her lower extremities. No injuries were noted. The note lacked evidence of the root cause analysis for the fall. Staff documented they have requested the provider to reconcile R1's medications to promote improved sleep patterns; however, this intervention alone did not substitute for a comprehensive RCA to determine why the fall occurred or how to prevent recurrence. R1's progress note dated 3/18/26 at 00:17 a.m., indicated R1 experienced unwitnessed fall on 3/17/26 at 10:10 p.m. Staff found R1 lying next to her bed, partially on the fall mat and partially on the floor, positioned on her left side. Her brief on the bed, and she was incontinent of urine. R1 did not sustain any visible injuries and transferred back to bed using a full mechanical lift. The note lacked evidence of the RCA. R1's treatment administration record dated March 2026, indicated R1 had a fall on 3/29/26 at 1:00 p.m. with no injury. R1's record did not include a comprehensive root cause analysis. = R1 experienced seven unwitnessed falls between 2/25/26 and 3/17/26. During this period, R1's psychiatric mental health evaluation identified a need for continuous supervision, yet across these events, the facility's documentation showed inconsistent completion of root cause analyses and limited evidence of comprehensive evaluation of contributing factors as directed by R1's care plan. Despite these recommendations, the facility did not consistently assess or address the factors contributing to R1's repeated falls, the care plan was not updated to reflect the psychiatric recommendation for enhanced supervision. During an interview on 4/20/26 at 5:23 p.m., a	20830		05/27/2026

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20830	Continued from page 4 family member (FM)-A stated she was not always informed about R1's fall incidents. FM-A reported R1 should be toileting every two hours while awake but this was not happening, especially when agency staff were working. FM-A explained staff did not pay attention to R1's needs, which my increase her behavior resulting in falls. FM-A stated she came to visit R1 on 4/18/26 and she was incontinent with urine, her WC was wet and smelling. R1 was sitting alone in the pod, and she had to call an NA to help R1. FM-A stated she did not report the incident to the nurse manager because they would not do anything to address the issue as always. During an interview on 4/20/26 at 1:03 p.m., a nursing assistant (NA)- A stated R1 "tries to get up without help a lot" and "we don't always have someone right there to watch her." NA-A explained she had been walking in the hallway past R1's room when she observed R1 lying on the floor next to her bed, partially on the fall mat, on 3/17/26. NA-A stated R1's brief was on the bed, and R1 was incontinent of urine at the time. NA-A stated she immediately notified the nurse, who came to assess R1 before R1 was transferred back to bed using a mechanical lift. NA-A stated she was not aware of any new interventions added after R1's repeated falls. During an interview on 4/20/26 at 1:48 p.m., NA-B stated R1 had experienced multiple falls in her room and R1 needed to be checked every two hours to prevent further falls. NA-B reported R1 might be highly sensible to environmental factors such as noise, loud music, or light which could contribute to her repeated fall incidents. NA-B stated she did not recall any team discussions on the unit regarding R1's multiple falls or strategies to prevent recurrence. NA-B explained they were not aware of any new interventions added following R1's repeated falls. During an interview on 4/20/26 at 2:49 p.m., a licensed practical nurse (LPN)-A who served as R1's case manager stated R1 was "one of the frequent fallers" and she was aware of her multiple fall incidents. LPN-A reported she did not provide any education to the staff regarding R1's repeated falls or the corresponding interventions needed to ensure R1's safety. LPN-A stated she was not sure who updated R1's care plan following the falls. LPN-A reported she was unaware of R1's psychiatric mental health evaluation dated 2/25/26, which recommended 24-hour supervision to ensure R1's safety. LPN-A confirmed that supervision levels were not increased despite R1's ongoing fall	20830		05/27/2026

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20830	Continued from page 5 pattern. During an interview on 4/20/26 at 3:46 p.m., a registered nurse RN-A stated R1 “had been falling a lot lately,” but the care plan “hadn’t really changed.” RN-A reported she completed the post fall evaluation on 2/26/26 for R1’s unwitnessed fall on 2/18/26, during which R1’s WC became stuck in a curve of the wall and R1 slipped out of WC, landing on pedals. RN-A stated she did not know what was decided during the interdisciplinary meeting regarding R1’s falls. RN-A also reported she was unable to locate documentation in R1’s medical record indicating whether a comprehensive assessment had been completed to guide an effective plan to prevent further falls. RN-A reported she was unaware of R1’s psychiatric mental health evaluation dated 2/25/26, which recommended 24-hour supervision to ensure R1’s safety. RA-A confirmed that supervision levels were not increased despite R1’s ongoing fall pattern. During an interview on 4/20/26 at 4:16 p.m., the director of nursing (DON) stated R1 was a frequent faller, and the facility had been trying to work with FM-A to determine what interventions might work better for R1. The DON stated she did not know whether each fall had been reviewed to identify the root cause analysis with corresponding interventions to prevent recurrence. The DON stated she expected staff to complete a comprehensive assessment after multiple falls to determine to the root cause; however, she was unable to locate any comprehensive assessment in R1’s medical record despite multiple falls. The DON reported she was unaware of R1’s psychiatric mental health evaluation dated 2/25/26, which recommended 24-hour supervision to ensure R1’s safety. The DON confirmed that supervision levels were not increased despite R1’s ongoing fall pattern. The DON explained since R1’s psychiatric mental health evaluation on 2/25/26, R1 had experienced seven fall incidents with no injuries. The DON confirmed staff did not update R1’s care plan to reflect the psychiatric recommendations. The DON stated R1 should have had additional interventions added and that the facility “did not follow through”. Fall Prevention and Management Policy dated 6/5/23 indicated the care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. The policy also directed staff to complete a falls analysis when a resident has two or more falls, to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and	20830		05/27/2026

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20830	Continued from page 6 if needed to determine additional interventions. Additionally, the policy indicated the facility will educate staff, residents, and families to promote a culture of safety, to keep residents safe and reduce falls risks. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures related to falls, accidents and resident supervision to ensure proper assessment and interventions are being implemented. The DON or designee could re-educate staff on this policies and procedures, and audit periodically to ensure the needs of resident(s) are maintained. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		05/27/2026