



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 7, 2026

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

RE: CCN:245399

Cycle Start Date: June 30, 2026

Dear Administrator:

On June 30, 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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Office: 218-302-6186 Mobile: 651-279-5375

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 September 30, 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 December 30, 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
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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July 7, 2026

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

Re: Event ID: 237833-H1

Dear Administrator:

The above facility survey was completed on June 29, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/30/2026	
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 From 6/29/26 to 6/30/26, an abbreviated survey was completed by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaint was reviewed: H53993067C (3054340, 3054476); with non-compliance cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			07/22/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to comprehensively assess a change in bowel status and, if needed, implement interventions to prevent complication (i.e., obstruction, discomfort) for 1 of 3 residents (R3) reviewed. R3 developed consistent loose stools on 6/20/26 which were not			F0684	F684 Plan of Correction - Quality of Care Deficient Practice: The facility failed to comprehensively assess a change in bowel status, and if needed, implement interventions to prevent complication. (R3). The facility failed to update or communicate the results of completed medical testing with the primary hospice team. The rationale for testing and subsequent test results were never shared with hospice to ensure appropriate coordination of care. (R1). 1. Corrective Action for Resident Found Affected • R3 has had a new bowel and bladder comprehensive assessment completed in full		07/22/2026

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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F0684 SS = D	Continued from page 1 evaluated or assessed, and R3 then admitted to the hospital on 6/25/26 with a potential bowel obstruction. In addition, the facility failed to update or communicate the results of completed medical testing (i.e., lab results, urinalysis) with the primary hospice team for 1 of 3 residents (R1) reviewed. R1 had multiple laboratory tests ordered on 6/5/26; however, the rationale for testing and subsequent test results were never shared with hospice to ensure appropriate coordination of care. Findings include: BOWELS NOT ASSESSED: R3's last completed and signed Bowel and Bladder Comprehensive, dated 4/29/25, identified R3 has being occasionally incontinent of bowel and needing extensive assistance with most activities of daily living (ADLs). The assessment left several sections blank with no recorded data present and outlined at the bottom that no changes to the care plan were made. R3's most recent Bowel and Bladder Comprehensive, dated 3/26/26, identified the evaluation remained, "In Progress," and was not signed as completed. The evaluation identified multiple sections to record various data points including catheter use, restorative potential, bladder observation and bowel function. However, the sections for bowel function, labeled as "Bowel Observations" and "Bowel Program Selection," were both left blank, and no recorded data was present. R3's annual Minimum Data Set (MDS), dated 4/1/26, identified R3 had short and long-term memory impairment but was always continent of bowel. The MDS recorded R3 as not being on a toileting program for bowels and having no constipation present. R3's corresponding Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) identified urinary incontinence as an actual problem which would be addressed in care planning. However, the completed CAA lacked any recorded data or review of R3's bowel status or bowel incontinence. R3's care plan, printed 6/30/26, identified R3's potential and actual problems along with interventions to address them. This outlined R3 had an activity of daily living (ADL) self-care deficit due to dementia and required assistance of two (A2) with a PAL lift for toileting and wore XL green briefs. Further, R3 had bowel incontinence and staff were to ensure he was placed on the toilet when being			F0684	Continued from page 1 completed on 7/10/2026 interventions were added to R3's care plan. • R3's care plan has been updated to reflect current bowel and bladder functioning and interventions for incontinence. • R1 's hospice provider was made aware of the lab results during the MDH investigation. R1 passed away on 6/25/26. 2. Identification of Other Residents Who May Be Affected • All residents with bowel incontinence may be affected by this deficient practice. All residents with bowel incontinence have had the last 7 days of bowels reviewed. No severe changes were noted that required intervention. (Will need an audit for this with all residents identified). • All residents on hospice may be affected by this deficient practice. All residents on hospice were reviewed to ensure communication with the primary provider, ancillary services, and laboratory results have been communicated effectively with the hospice provider. No residents on hospice had received lab orders. 3. Systemic Changes to Prevent Reoccurrence Bowel/Bladder Bowel/Bladder Comprehensive: * The process for bowel monitoring was reviewed with changes initiated. On the night shift the overnight nurse will review the BM list and per list enter the required SHO. This list will be signed and dated by night nurse prior to being turned into RN case manager. RN Case manager signs off on this once reviewed with progress note documented		07/22/2026

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F0684 SS = D	Continued from page 2 changed for the day, staff allowed him to sit and empty his bowels on the toilet, and staff toileted R3 every 4 hours and as needed (PRN). The section of the care plan which identified R3 as being incontinent of bowel was last updated 4/2026. R3's POC (Point of Care) Response History, dated 6/1/26 to 6/29/26, identified R3's recorded bowel movements in the EMR charting. The data recorded the size of movement along with its consistency. From 6/10/26 to 6/19/26, R3 had 15 recorded bowel movements with only four (4) recorded as loose/diarrhea. From 6/20/26 to 6/25/26, R3 had 10 bowel movements. However, now seven (7) of the ten were recorded as loose/diarrhea. R3's Medication Administration History (MAR), dated 6/2026, identified R3's provided medications for the month period. R3 was recorded as having PRN laxative medications available, such as Miralax, but there were no recorded administrations of these medications recorded for the month. R3's progress note, dated 6/25/26, identified R3's family member notified staff R3 was having "a medical emergency" and the nurse responded. R3 was found with a large amount of emesis on his chest and his abdomen "very distended." R3 was transferred to the hospital via EMS. The note concluded, "[Family] called with update ... had a small bowel obstruction ... Plan is to see surgeon in the morning." R3's corresponding hospital Admission H&P, dated 6/26/26, identified R3 was admitted to the hospital from the emergency department (ED) for vomiting and abdominal distention. R3 had a PEG tube (Percutaneous Endoscopic Gastrostomy; a flexible feeding tube surgically placed through the abdominal wall directly into the stomach) in place for several years prior and a CT scan of the abdomen recorded, " ... distended with air and fluid, concerns for enteritis or partial obstruction." R3's medical record lacked evidence of any fully completed and signed bowel assessments since 4/2025 (over a year prior). Further, the record lacked evidence that R3's developed consistent loose stools (starting 6/20) were acted upon and assessed to determine what, if any, interventions were needed to reduce them or if more evaluation (i.e., notification to the provider) was needed. When interviewed on 6/30/26 at 9:03 a.m., nursing assistant (NA)-E stated bowel movements were tracked on a paper form and then entered to the			F0684	Continued from page 2 regarding baseline/changes to bowels and turned into the DON. TMA/Nurses will be educated on this change in process on 7/22/26. Re-education on SHO's bowel medications to utilize for TMAs/Nurses. Nurse Leadership re-education on completing bowel and bladder comprehensives when changes are noted as well as completing all sections of the assessments. Hospice Communication: * Hospice Case Managers have access to PointClickCare to review the resident's medical records. In addition, a form was created to communicate with hospice services. All Nurse Managers and Hospice Nurses received the education for this process change and review of the form by 7/22/2026. 4. Monitoring • The Nurse Managers will audit all residents' bowel movements on a bi-weekly basis to ensure that PRN bowel medications are being utilized and documented per Standing House Orders, if appropriate. In addition, the audit will monitor for changes in the resident's normal bowel patterns. • Bowel audits will be conducted weekly for 6 weeks. • The DON will audit all hospice communication forms completion on a weekly basis to ensure communication of orders, ancillary services, labs, are being appropriately communicated to hospice providers. • Hospice audits will be conducted weekly for 6 weeks.		07/22/2026

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F0684 SS = D	Continued from page 3 computer charting. The NA who helped a resident when they had a bowel movement was responsible for charting it. The nurses would then assess the person and report to the NA how often they would be toileted. NA-E recalled working with R3 and stated he did not speak and would be incontinent of bowel “every now and then” only. NA-E stated they had noticed prior to R3 being hospitalized that his stools were “loose and watery” but were unsure if this was a change for him as they only worked casual shifts. In the past though, NA-E stated R3’s stools were more on the “soft, formed side.” NA-E stated they were unsure if R3 used any laxative medications or not, and R3 had used tube feeding for several years prior to this hospitalization. Further, NA-E stated if they recognized a change in a resident then they’d report it to the nurse. When interviewed on 6/30/26 at 9:15 a.m., registered nurse (RN)-B explained they worked for a pool agency but had worked multiple shifts at the care center. RN-B stated they had worked with R3, and he was currently hospitalized. R3 had a tube feeding which was “not brand new” to him. RN-B stated they were “not very sure” of R3’s bowel status as they only worked casually. However, if there was a change in bowel status the NA(s) had noticed, then they should report it, and the nurse would “assess.” RN-B stated a change in bowel movement consistency warranted an evaluation including bowel sounds and medication review as staff needed to determine where the change was coming from. RN-B stated they thought this process would be recorded in the progress notes or on a new Bowel and Bladder Comprehensive. On 6/30/26 at 10:05 a.m., a group interview was held with the director of nursing (DON), licensed practical nurse manager (LPN)-A, registered nurse case manager (RN)-C, and the RN/MDS coordinator (RN)-E. R3’s medical record was reviewed and RN-E explained they complete a bowel evaluation using a “look back report” which captures the NA recorded data on bowel movements and continence. That information was then pulled to the MDS and completed on the Bowel and Bladder Comprehensive in the EMR. The RN was responsible for doing that evaluation, but an LPN could contribute. RN-E stated the facility had just recently changed to doing the comprehensive evaluations every quarter as prior they were only done annually. RN-E verified R3’s last completed Comprehensive had the data for the bowel sections left blank adding they “didn’t finish it.” They didn’t complete it as they did not get along with R3’s family member who was often present in his room. RN-E stated the missed data collection			F0684	Continued from page 3 - Any identified concerns will be addressed promptly through corrective action and staff education as indicated. - The DON will oversee the completion of the audits and compliance with the process changes. - The QAPI Committee will evaluate findings, identify trends, and determine whether additional interventions or monitoring are necessary to maintain compliance. Monitoring may be extended if compliance is not sustained.		07/22/2026

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F0684 SS = D	Continued from page 4 was a reason they had asked to adjust these evaluations to quarterly and not just annually. RN-E added it was "to improve our cares." RN-E then reviewed R3's POC charting and stated the data showed "a change" in bowel consistency on 6/21/26 and wondered if anyone had reported it or evaluated it. LPN-A and RN-C both stated none of the aides had reported anything to them about R3 having loose stools. RN-E verified the medical record lacked evidence that the change of bowel status had been evaluated or assessed and explained any change like that should be acted upon to determine if the physician needs to be involved or not. DON stated they felt R3's hospitalization was likely unavoidable given the wife would want treatment options for a potential obstruction which the care center could not perform. A facility policy on bowel assessment or evaluation was requested; however, none was received. A provided Assessment Matrix, dated 6/26/26, identified each assessment of the facility they completed and when to complete them. This identified nursing would complete the Bowel and Bladder Comprehensive on, "Annual/Sig [sig change]." HOSPICE COORDINATION: R1's quarterly Minimum Data Set (MDS), dated 5/8/26, identified R1 had moderate cognitive impairment but no infections. A subsequent Discharge Return Anticipated MDS, dated 6/23/26, identified that R1 was admitted to the short-term general hospital. R1's Fax Cover Page, dated 6/5/26, identified the physician office faxed a series of orders to the care center from the medical doctor (MD). These included orders to draw multiple laboratory tests including a Complete Blood Count (CBC), metabolic panel (CMP), magnesium, phosphorus, and complete urinalysis (UA). The order listed a diagnosis for these as, "Acute Confusion." R1's Health Laboratory (Results), dated 6/8/26, identified the tests were collected on 6/8/26 and showed the results. R1 was recorded with an elevated Creatinine, Blood Urea Nitrogen (BUN), and a decreased (low) red blood cell (RBC) count and hemoglobin. The UA showed, "<10,000 colonies ... Probable contaminant(s)." R1's Hospice Visit Communication (record), dated 1/29/26 to 6/23/26, identified the registered nurse			F0684			07/22/2026

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F0684 SS = D	Continued from page 5 (RN) entries recorded on a paper format. R1 admitted to hospice on 1/29/26. This identified a total of nine (9) visits for June 2026 with the last entry on 6/23/26, "Vitals low (BP, O2) Pulse [elevated] sent to ER per family." The notes lacked evidence that R1's completed labs on 6/8/26 were discussed or provided to hospice. R1's entire medical record, including progress notes, lacked evidence the laboratory testing was reported to the hospice agency for R1 to ensure hospice was involved in the decision making for R1 and to promote continuity of care. When interviewed on 6/29/26 at 11:57 a.m., hospice nursing assistant (NA)-B stated they had worked with R1 at the care center. R1 had several wounds on her legs and bottom and had become more tired as June 2026 progressed. NA-B stated R1's primary hospice nurse was RN-G who mostly helped with orders and treatments. NA-B stated there had been some issues with hospice care coordination at the care center over the past months but felt it was "getting better" lately as the hospice management had visited with the facility leadership prior about some issues. When interviewed on 6/29/26 at 12:23 p.m., hospice registered nurse (RN)-G stated they were R1's primary hospice nurse while R1 resided at the care center before her passing. R1's medical record was reviewed with RN-G who stated they were unaware R1 had lab testing completed on 6/8/26. RN-G added, "We were not made aware of that." RN-G stated they would have liked to have been updated those tests were done and with the results and reiterated, "I didn't know that happened." RN-G stated they did not have EMR access at the care center to see them without staff notification, but the care center was working on getting them access. The center and hospice relied on "a lot of verbal communication" to ensure continuity of care between them and RN-G stated there were times when some care things, like falls and this lab testing example, which didn't always get reported timely to hospice. RN-G stated a meeting was scheduled upcoming between hospice and the care center to discuss R1 (related to a missed antibiotic) and added they felt they were getting all the information on their other patients in the center adding further, "I hope so." When interviewed on 6/29/26 at 1:02 p.m., RN-K stated the nurse manager or case manager would be the one responsible to update hospice with new orders or lab testing results. RN-K stated they had			F0684			07/22/2026

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NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345			
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F0684 SS = D	Continued from page 6 never been told or asked to do that prior as a floor nurse and reiterated the unit managers would handle it. On 6/29/26 at 2:02 p.m., a group interview was held with several members of the care center leadership present including the director of nursing (DON), administrator, licensed practical nurse manager (LPN)-A, and registered nurse case manager (RN)-C. It was explained that R1 was admitted to hospice in January 2026 for end-stage pulmonary hypertension and either of the nurse managers could update hospice with new orders, lab testing results, or other care-related items. R1’s medical record was reviewed, and they explained that R1’s family had called her MD on 6/4/26 with concerns for acute confusion which is what prompted the lab orders to come to the care center. LPN-A stated they could not recall if they visited with hospice about the lab orders and results or not, but RN-C then stated any communication with hospice should have a progress note completed in the record to show such happened. They verified hospice should have been updated with the orders and results for the lab testing completed on 6/8/26 as hospice would make the decision to treat or not treat any abnormal results. A facility Hospice Services policy, dated 3/2022, identified the care center as responsible to designate a nurse to coordinate and supervise the services and be available to consult with hospice staff about the care plan. This included, “Collaborate with Hospice staff regarding resident changes in condition or Physician orders.” The policy added, “Coordination of Care – Hospice and care center staff will communicate with one another regularly and as needed for each hospice patient.”			F0684			07/22/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/30/2026	
NAME OF PROVIDER OR SUPPLIER LITTLE FALLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIRST AVENUE NORTHEAST , LITTLE FALLS, Minnesota, 56345			
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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: From 6/29/26 to 6/30/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure requirements. The following complaint was reviewed: H53993067C (3054340, 3054476) Minnesota Department of Health (MDH) is documenting State Licensing Correction Orders using Federal software. The facility is enrolled in			20000			07/22/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/30/2026	
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20000	Continued from page 1 ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			07/22/2026