DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JHTS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00324

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245542**

2.STATE VENDOR OR MEDICAID NO.
(L2) **154540000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLEFORK MEDICAL CENTER**
(L4) **BOX N, 900 MAIN STREET**
(L5) **LITTLEFORK, MN** (L6) **56653**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/03/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 11/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/11/14 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
__X__ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/24/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/31/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245542

November 12, 2014

Mr.. Michael Anderson, Administrator
Littlefork Medical Center
Box N, 900 Main Street
Littlefork, Minnesota 56653

Dear Mr.. Anderson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective October 8, 2014 the above facility is certified for:

50 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 12, 2014

Mr.. Michael Anderson, Administrator
Littlefork Medical Center
Box N, 900 Main Street
Littlefork, MN 56653

RE: Project Number S5542023

Dear Mr.. Anderson:

On September 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 10, 2014 that included an investigation of complaint number . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On November 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 8, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 10, 2014, effective October 8, 2014 and therefore remedies outlined in our letter to you dated September 16, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5542s14

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245542	A. Building B. Wing	11/3/2014

Name of Facility	Street Address, City, State, Zip Code
LITTLEFORK MEDICAL CENTER	BOX N, 900 MAIN STREET LITTLEFORK, MN 56653

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/06/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/19/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/08/2014**
ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **09/19/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** LB/mm	**Date:** 11/12/2014	**Signature of Surveyor:** 28035	**Date:** 11/03/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/10/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JHTS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00324

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(L1) **245542**
2.STATE VENDOR OR MEDICAID NO.
(L2) **154540000**

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(L3) **LITTLEFORK MEDICAL CENTER**
(L4) **BOX N, 900 MAIN STREET**
(L5) **LITTLEFORK, MN** (L6) **56653**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/10/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NEII 09/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 10/30/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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3. Both of the Above :

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04/24/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 16, 2014

Mr. Michael Anderson, Administrator
Littlefork Medical Center
Box N, 900 Main Street
Littlefork, Minnesota 56653

RE: Project Number S5542023

Dear Mr. Anderson:

On September 10, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 20, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 20, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 December 10, 2014 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 March 10, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5542s14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	09/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	**BOX N, 900 MAIN STREET LITTLEFORK, MN 56653**

(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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		10/6/14

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

Electronically Signed | 09/24/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	09/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	BOX N, 900 MAIN STREET LITTLEFORK, MN 56653

(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
F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a dosage reduction was attempted, unless clinically contraindicated and clinical justification for the continued use of lorazepam (anti-anxiety medication) was documented and/or tapering of the medication was performed for 1 of 5 residents (R29) whose medication regimen was reviewed. Findings include: R29's Diagnosis Listing by Resident dated 9/10/14, indicated R29 had diagnoses included dementia with behavioral disturbance, episodic mood disorder, psychosis, anxiety, depressive disorder and Alzheimer's Disease. R29's Psychosocial Well-being Care Area Assessment (CAA) dated 4/1/14, indicated R29 was more aggressive towards staff in the past, particularly with bathing and toileting but was less so now. The CAA also indicated R29 was being followed by a provider for management of her psychotropic (mood altering) medications as they related to her behaviors. R29's Psychotropic Drug Use CAA dated 4/1/14, indicated R29's behaviors were well controlled and R29 was not overly anxious nor aggressive most of the time. The CAA indicated referrals were to be made as needed to evaluate psychotropic medications. R29's quarterly Minimum Data Set (MDS) dated	F 329	This plan and response to CMS 2567 regarding 483.25(l) is written solely to maintain certification in the Medicare and Medical Assistance Programs. We wish to preserve our rights to dispute these findings in their entirety should any remedies be imposed. Without jeopardizing our right to challenge the validity of the F-tag and without admitting that any non-compliance with this regulation exists, we have instituted the following measures: Regarding R (29), resident was seen by behavior specialist Kathi Hendrickson, FNP on 9/19/14 for reduction trial of anti-anxiety medication. A psychotropic reduction log will be implemented for residents on psychotropic meds requiring reductions and reviewed by RN at care conferences. 9/19/14 Psychotropic reductions will be attempted/reviewed every 6 months for the first year on the medication and then annually by RN. RN will notify practitioner on rounds if reduction is to be attempted or documentation is put in place if contraindicated. Documentation will be in place regarding contraindications for	

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	245542	A. BUILDING _____ B. WING _____	09/10/2014

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F 329	Continued From page 2 6/26/14, indicated R29 had severe cognitive impairment, was rarely/never understood, had no mood symptoms and had hallucinations without exhibited behavior directed towards others. R29's Physician Orders dated 8/7/14, indicated R29 was prescribed lorazepam (anti-anxiety medication) 1.0 milligram (mg) orally twice a day and lorazepam 2.0 mg/milliliter (ml) injection solution with 0.5 ml given intramuscularly three times a day as needed for physical aggression. R29's care plan dated 9/10/14, indicated R29 was to receive lorazepam 1.0 mg by mouth twice a day and lorazepam 1.0 mg intramuscular injection three times a day as needed for physical aggression. The care plan directed staff to monitor R29 for verbal aggression, physical aggression, agitation/restlessness, sadness/depression, anxiety, pain and changes in cognition. Staff were also directed to monitor for side effects related to the administration of mood-altering medications. R29's Nursing Home Note dated 3/14/14, indicated R29 had tolerated a dose reduction of Seroquel (antipsychotic medication) until just recently when R29 began having an increase in combativeness and distressful hallucinations. The note indicated the Seroquel was then increased back to the original dose and since that time R29 had been stable, behaviors were gone, hallucinations were not too distressful and had occasional episodes of combativeness, but was easily redirected. Other psychotropic medications were identified to include lexapro (antidepressant) 10 mg daily, tegretol (mood stabilizer) 100 mg twice a day, and lorazepam 1 mg twice a day. The Nursing Home Note plan	F 329	reduction. 9/12/14 Training will be held with RN□s regarding policies on psychotropic medications and reduction plans on 10/6/14. Auditing: Auditing of psychoactive drug reduction log and charts will be completed monthly for four months, then every other month for 6 months. Audits will be performed by Director of Nursing. Audit results will be reported and reviewed every month for ten months at our QA meeting.	

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F 329	Continued From page 3	F 329		

section identified the provider would not attempt to decrease the Seroquel in the next year, recommended R29 stay on the lexapro because of underlying chronic depression prior to the onset of dementia and identified previous attempts to decrease tegretol increased R29's behaviors. The provider also recommended continuing lorzepam 1 mg twice a day but did not provide a clinical rationale for its continued use.

On 9/9/14, at 1:12 p.m. R29 was observed resting in bed, positioned slightly to her left side with her eyes closed. A mat was observed on the floor next to the bed and a large body pillow was placed on the outside edge of the bed on R29's right side.

On 9/10/14, at 8:00 a.m. R29 was observed seated in a reclined geri chair in the dining room waiting for breakfast. R29 was resting quietly and did not make eye contact. No agitation, restlessness or combativeness was observed.

On 9/10/14, at 9:18 a.m. nursing assistant (NA)-A stated she was familiar with R29. NA-A stated R29 had behaviors in the past that included pinching, grabbing and hitting, however, stated R29 was much better now. NA-A stated it had been several months since R29 had exhibited these behaviors. NA-A indicated she had just put R29 in bed and R29 was cooperative and sleepy. NA-A also stated they watched for behaviors and charted daily on them and reported any behaviors to the nurses.

On 9/10/14, at 9:22 a.m. NA-B stated she was familiar with R29. NA-B stated R29 had been much more cooperative lately. NA-B indicated R29 used to pinch, scratch and grab at the staff

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F 329	Continued From page 4	F 329		

when cares were provided. NA-B stated R29 hadn't done that in about 3 months. NA-B also stated she had noticed an improvement in R29's behaviors since they started using a mechanical lift for transfers. NA-B indicated the NAs watched and charted behaviors for R29 such as combativeness.

On 9/10/14, at 9:38 a.m. licensed practical nurse (LPN)-B stated she was familiar with R29 and had recently assisted R29 to bed. LPN-B stated R29 was a little resistive to cares at that time, but not combative. LPN-B stated R29 had been much better the past several months. LPN-B volunteered that R29 may have been due for a dosage reduction of her psychotropic medication and indicated they had tried reductions in the past. LPN-B stated attempts to reduce tegretol was unsuccessful and R29 had increased behaviors afterwards. LPN-B also stated they were able to successfully reduce R29's Seroquel this past December and indicated the provider who managed R29's medications was due to come to the facility on 9/17/14.

On 9/10/14, at 11:34 a.m. LPN-B confirmed R29 was started on lorazepam on 5/20/13, and indicated the provider may have been due to look at the lorazepam. LPN-B indicated R29 had been on the schedule to see the provider on 9/17/14, however, since R29 was stable and the provider's schedule was full, R29's appointment was moved to October.

On 9/10/14, at 1:45 p.m. consulting pharmacist (CP) indicated she would want R29 to stabilize from the last medication change before adjusting any additional medications. CP stated she could not recall the specifics of R29's history at that

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F 329	Continued From page 5 time but in general, would recommend trying again after 2 months if there were no other complicating medical issues. On 9/10/14, at 2:10 p.m. registered nurse (RN)-A confirmed a tapering of R29's lorazepam dose had not been attempted and R29's chart lacked rationale for its continued use. RN-A also stated R29 had been stable and had not had any medical conditions that would interfere with an attempt to taper the lorazepam dose. On 9/10/14, at 2:12 p.m. director of nursing (DON) confirmed a tapering of lorazepam should have been attempted or a clinical rationale for the continued use of lorazepam should have been documented. On 9/10/14, at 3:25 p.m. RN-A stated they used to complete a Psychotropic Drug Reduction Log which tracked residents taking psychotropic medications. RN-A stated the log was reviewed for tracking when residents were due for possible reductions in the medication. RN-A indicated the log had not been completed since 1/20/12. The Psychotropic Medications & Behavior Monitoring policy dated 04/07, indicated a Psychotropic Drug Reduction Log would be reviewed by the RN during the MDS/care plan review process. The policy also indicated any resident admitted or initiated on a psychotropic medication would be placed on this log. The policy further indicated after the first year on a psychotropic medication, a dose reductions must be attempted annually, unless clinically contraindicated and documented so by the physician.	F 329		

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F 428	Continued From page 6	F 428		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities related to the lack of a dose reduction and clinical justification for the continued use of an anti-anxiety medication (lorazepam) for 1 of 5 residents (R29) whose drug regimen was reviewed for unnecessary medications. Findings include: R29's Diagnosis Listing by Resident dated 9/10/14, indicated R29 had diagnoses that included dementia with behavioral disturbance, episodic mood disorder, psychosis, anxiety, depressive disorder, and Alzheimer's Disease. R29's Psychosocial Well-being Care Area Assessment (CAA) dated 4/1/14, indicated R29 had been more aggressive towards staff in the past, particularly with bathing and toileting but was less so now. The CAA also indicated R29	F 428	This plan and response to CMS 2567 regarding 483.60(c) is written solely to maintain certification in the Medicare and Medical Assistance Programs. We wish to preserve our rights to dispute these findings in their entirety should any remedies be imposed. Without jeopardizing our right to challenge the validity of the F-tag and without admitting that any non-compliance with this regulation exists, we have instituted the following measures: Consulting pharmacist was notified of tag and reviewed R (29) medications and charting regarding reduction of anti-anxiety medication on 9/13/14. Pharmacist review form will be modified to add a specific area for psychotropic medication reduction implementation. 9/19/14	9/19/14

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F 428	Continued From page 7 was being followed by a provider for management of her psychotropic (mood altering) medications as they related to her behaviors R29's Psychotropic Drug Use CAA dated 4/1/14, indicated R29's behaviors were well controlled and R29 was not overly anxious or aggressive most of the time. The CAA indicated referrals were to be made as needed to evaluate psychotropic medications. R29's quarterly Minimum Data Set (MDS) dated 6/26/14, indicated R29 had severe cognitive impairment, was rarely/never understood, had no mood symptoms present, had no behaviors and had hallucinations, however, exhibited no behavioral symptoms directed towards others. R29's Physician Orders dated 8/7/14 indicated R29 received lorazepam 1.0 milligrams orally, twice a day and lorazepam 0.5 milliliters (ml) of 2.0 mg/ml injection solution intramuscularly three times a day as needed for physical aggression. R29's care plan dated 9/10/14, indicated R29 was to receive lorazepam 1 mg by mouth twice a day. The care plan also identified R29 could have lorazepam 1 mg intramuscular injection three times a day as needed for physical aggression. The care plan further directed staff to monitor R29 for verbal aggression, physical aggression, agitation/restlessness, sadness/depression, anxiety, pain and changes in cognition. Staff were also directed to monitor for side effects related to the administration of the mood-altering medications. R29's Nursing Home Note dated 3/14/14, indicated R29 had tolerated a dose reduction of	F 428	A new form for consulting pharmacist visits was reviewed by consulting pharmacist on 9/13/14. Auditing: Audits of the pharmacist review forms will be completed every month (to check for psychotropic reduction recommendations) for four months, then every other month for 6 months. Audits will be performed by Director of Nursing. Audit results will be reported and reviewed every month for ten months at our QA meeting.	

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F 428	Continued From page 8	F 428		

Seroquel (antipsychotic medication) until just recently when R29 began having an increase in behaviors, combativeness and distressful hallucinations. The note indicated the Seroquel was then increased back to the original dose and since that time R29 had been stable, behaviors were gone, hallucinations did not seem too distressful and had occasional episodes of combativeness, but was easily redirected. Other psychotropic medications identified included lexapro (antidepressant) 10 mg daily, tegretol (mood stabilizer) 100 mg twice a day, and lorazepam 1 mg twice a day. The Nursing Home Note plan section indicated R29's physician would not attempt to decrease the Seroquel in the next year and recommended R29 stay on the lexapro because of underlying chronic depression prior to the onset of dementia and identified previous attempts to decrease tegretol increased R29's behaviors. The physician also recommended continuing lorzepam 1 mg twice a day but did not provide a clinical rationale for its continued use.

Review of the Pharmacist's Monthly Drug Regimen Review Form indicated the consulting pharmacist (CP) reviewed R29's record on 5/18/13, 6/8/13, 7/13/13, 8/17/13, 9/14/13, 10/12/13, 11/3/13, 12/7/13, 1/4/14, 2/8/14, 3/10/14, 4/5/14, 5/10/14, 6/9/14, 7/18/14, and 8/16/14. The CP made recommendations on 11/3/13, 4/5/14, and 6/7/14, however, the recommendations did not include tapering of the lorazepam nor was the lack of rationale for continued use of lorazepam identified.

On 9/10/14, at 1:45 p.m. CP indicated she would want R29 to stabilize from the last medication change before trying something else. CP stated she could not recall the specifics of R29's history

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F 428	Continued From page 9 at that time but in general, would recommend trying again after 2 months if there were no other complicating medical issues. On 9/10/14, at 2:10 p.m. registered nurse (RN)-A confirmed a tapering of R29's lorazepam dose had not been attempted and R29's chart lacked rationale for its continued use. RN-A also stated R29 had been stable and had not had any medical conditions that would interfere with an attempt to taper the lorazepam dose. On 9/10/14, at 2:12 p.m. director of nursing (DON) confirmed there was no recommendation by the CP in R29's record regarding tapering of lorazepam nor did CP identify the lack of rationale for continued use of the medication. The Pharmaceutical Services policy dated 2/03, indicated the pharmacist reviewed the drug regimen of each resident at least monthly and reported any irregularities to the medical director and administrator.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		10/8/14

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F 441	Continued From page 10 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain appropriate infection control measures while storing reusable cold packs in a refrigerator next to perishable food. This had the potential to affect all 47 residents who resided in the facility. Findings include: On 9/10/14, at 9:16 a.m. licensed practical nurse (LPN)-A was observed to open a small	F 441	This plan and response to CMS 2567 regarding 483.65 is written solely to maintain certification in the Medicare and Medical Assistance Programs. We wish to preserve our rights to dispute these findings in their entirety should any remedies be imposed. Without jeopardizing our right to challenge the validity of the F-tag and without admitting that any non-compliance with this regulation exists, we have instituted the following measures:	

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F 441	Continued From page 11 refrigerator in the East hallway. LPN-A removed a reusable cold pack from the refrigerator. LPN-A stated the cold pack would be used for resident (R) 33's sore finger. LPN-A explained when R33 was done with the cold pack she would wash it off and return it to the refrigerator. At 9:20 a.m. the East hallway refrigerator was observed with registered nurse (RN)-A. The refrigerator contained an 8 pack of boost (nutritional supplements), 3 containers of yogurt, 8 cans of soda, 3 bottles of water, 2 fresh cucumbers, nacho cheese dip, mustard, ketchup, and a can of whip cream. RN-A stated the refrigerator was utilized by the residents to store their personal food items. She verified the refrigerator contained both cold packs used for resident comfort and their personal food. On 9/10/14, at 1:10 p.m. the director of nurses (DON) verified the facility practice was to keep the cold packs in the resident refrigerator on the East wing along with the residents personal food items. She confirmed this practice was not an appropriate infection control practice. Review of the Resident Care Application of Ice Pack policy dated 6/30/1997, directed staff how to maintain cold packs in which the facility was to create. At 1:15 p.m. the DON verified the policy did not address the use or storage of reusable cold packs. She stated the policy was outdated and was in need of revision.	F 441	Reusable ice packs will be disposed of and replaced with ice packs made from disposable plastic bags and ice. These ice packs will be disposed of after each use and not stored. Ice packs for coolers on medication carts will be stored in a tote separate from food items. 9/19/14 A policy has been written to address the usage and storage of ice packs separate from perishable food within the facility. 9/19/14 Training for RN□s and LPN□s will held to review policy on usage and storage of ice packs on 10/6/14 and 10/8/14 Auditing: Audits will be completed every month for three months to ensure ice packs are being stored per policy, then every other month for 6 months. Audits will be performed by Director of Nursing. Audit results will be reported and reviewed every month for nine months at our QA meeting.	
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care	F 456		9/19/14

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F 456	Continued From page 12 equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the warming cabinet was safely maintained which had the potential to affect all 47 residents who resided in the facility. Findings include: On 9/9/14, at 10:31 a.m. the outside digital temperature reading on the warming cabinet was observed to read 161 degrees Fahrenheit. At 10:40 a.m. the director of nursing (DON) confirmed the outside temperature of the warming cabinet read 159 degrees Fahrenheit. The DON verified the warming cabinet was utilized to warm blankets and towels for the residents. She stated nursing did not monitor or check the inside temperature of the warming cabinet nor was there a thermometer on the inside of the warming cabinet. On 9/9/14, at 12:58 p.m. the DON confirmed she had placed a thermometer between the blankets in the warming cabinet 30 minutes prior. The outside digital temperature reading on the warming cabinet was observed to be 159 degrees Fahrenheit and the thermometer inside the warming cabinet read 142 degrees Fahrenheit. On 9/9/14, at 1:36 p.m. the DON verified the warming cabinet was a donated item and it had been in the facility for some time. She was unsure if the facility had a policy or procedure	F 456	This plan and response to CMS 2567 regarding 483.70(c) is written solely to maintain certification in the Medicare and Medical Assistance Programs. We wish to preserve our rights to dispute these findings in their entirety should any remedies be imposed. Without jeopardizing our right to challenge the validity of the F-tag and without admitting that any non-compliance with this regulation exists, we have instituted the following measures: Blanket warmer temperature was reduced to 130 degrees. 9/10/14 A policy has been developed to address the blanket warmer and monitoring of temperatures. The temperature will be checked daily by housekeeping staff and recorded in a log. Housekeeping staff will contact Manager of Environmental Services if the temperature is above 140 or below 120 degrees. 9/19/14 Auditing: Audits will be completed every two weeks for the first two months to ensure monitoring is complete, then audits will be completed monthly for 6 months. Audits will be performed by the Director of Nursing. Audit results will be reported and reviewed every month for eight months at our QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	09/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	**BOX N, 900 MAIN STREET LITTLEFORK, MN 56653**

(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
F 456	Continued From page 13 regarding the use and monitoring of the warming cabinet and was unable to articulate a safe temperature range for this piece of equipment. On 9/10/14, at 7:30 a.m. the outside digital temperature reading on the warming cabinet was observed to be 159 degrees Fahrenheit and the contents of the cabinet included five bath towels and two bath blankets. On 9/10/14, at 8:00 a.m. the environmental service director (ESD) confirmed the maintenance department did not monitor the temperatures of the warming cabinet, nor was he able to verify a safe temperature range for this piece of equipment. The MAC MEDICAL DIGITAL WARMING CABINETS manual dated 12/2007, recommended checking the temperature on a semi-annual basis. No policy related to the warming cabinet use and maintenance was provided.	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	**BOX N. 900 MAIN STREET LITTLEFORK, MN 56653**

(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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Littlefork Medical Center 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Littlefork Medical Center was constructed at 2 different times. In 1978 the original building was constructed to the east of the 1964 hospital, is 1-story without a basement and is Type II (000) construction. In 1992 1-story additions were construction to the north and east wings and are Type II(000) construction. The facility is divided into 3 smoke zones by 30 minute fire barriers and separated from the old hospital building with a 2-hour fire barrier. The building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in all sleeping rooms, at the cross corridor smoke barrier doors and in common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/09/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	**BOX N. 900 MAIN STREET LITTLEFORK, MN 56653**

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K 000	Continued From page 1 The facility has a capacity of 50 beds and had a census of 47at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		