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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: OZZ5

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 **10/24/2013** (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:
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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sharron Williams, HFE NE II 11/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/20/2013 (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
Posted 12/31/2013 CO. OZZ5

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/14/2013
(L33)

DETERMINATION APPROVAL

CCN# 24-5542

At the time of the standard survey completed August 29, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On October 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on August 29, 2013 effective October 20, 2013, therefore the remedies outlined in our letter to you dated September 11, 2013, will not be imposed.
See the attached CMS-2567B form for the results of the October 24, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5542 December 20, 2013

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.

Effective October 20, 2013 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.

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 26, 2013

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

RE: Project Number S5542022

Dear Mr.. Anderson:

On September 11, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 29, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 29, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 9, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 29, 2013, effective October 20, 2013 and therefore remedies outlined in our letter to you dated September 11, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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	10/24/2013

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 **F0221** Reg. # **483.13(a)** LSC	Correction Completed **09/24/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/09/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **10/09/2013**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/20/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/08/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/20/2013**
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	Date:	Signature of Surveyor:	Date:
	LB/KJ	11/25/2013	19697	10/24/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/29/2013			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 25, 2013

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

Re: Enclosed Reinspection Results - Project Number S5542022

Dear Mr. Anderson:

On October 24, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 29, 2013, with orders received by you on September 14, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

I4Z4

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00324	A. Building B. Wing	10/24/2013

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20565**	Correction Completed **10/09/2013**	ID Prefix **20915**	Correction Completed **10/09/2013**	ID Prefix **21390**	Correction Completed **09/18/2013**
Reg. # **MN Rule 4658.0405 Subp. 1**		Reg. # **MN Rule 4658.0525 Subp. 6**		Reg. # **MN Rule 4658.0800 Subp. 4**	
LSC		LSC		LSC	
ID Prefix **21630**	Correction Completed **10/20/2013**	ID Prefix **21685**	Correction Completed **09/16/2013**	ID Prefix	Correction Completed
Reg. # **MN Rule 4658.1350 Subp. 1**		Reg. # **MN Rule 4658.1415 Subp. 1**		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/KJ	11/25/2013	19697	10/24/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/29/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OZZ5

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: **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 **08/29/2013** (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:
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

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):
At the time of the Standard survey, the facility was not in compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Sharron Williams, HFE NEII 10/01/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/18/13 (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
11/14/2013 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7012

September 11, 2013

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

RE: Project Number S5542022

Dear Mr.. Anderson:

On August 29, 2013, 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. In addition, at the time of the August 29, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5542010 that was found to be unsubstantiated.

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

Remedies - 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;

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

Informal Dispute Resolution - 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
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (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 8, 2013, 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 8, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 November 29, 2013 (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 1, 2014 (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 a PoC 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 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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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 _____ RECEIVED SEP 25 2013	08/29/2013

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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A standard recertification survey was conducted and a complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5542010 was completed. The complaint was not substantiated.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a physical restraint (lap tray) was the least restrictive device for 1 of 1 resident (R26) in the sample reviewed for potential restraints.	F 221	This plan and response to CMS 2567 regarding 483.13(a) 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.	Approved 10/1/13 SB Corrected 3 x 2 b 10/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Anderson	Administrator	9-24-13

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.

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F 221	Continued From page 1 Findings include: R26's diagnoses included Alzheimer's disease, dementia with behavior disturbances and anxiety. The quarterly Minimum Data Set (MDS) dated 7/11/13, indicated R26 had memory loss, severely impaired decision making skills and total dependence on two staff for transfers and mobility. The MDS indicated R26 had one fall since the last assessment period which resulted in an injury. The MDS also indicated R26 utilized a physical restraint daily, which prevented R26 from rising from a chair. The nurse progress note dated 5/29/13, indicated R26 fell from the Rock-n-Go wheelchair at 7:10 p.m., received a laceration to the forehead and was transported to the emergency room via ambulance for evaluation and treatment. A physical therapist (PT) progress note dated 5/31/13, indicated R26 had been leaning forward in the Rock-n-Go wheelchair which was not safe as R26 was unaware of the increased risk of falling. The PT note also indicated a lap tray was implemented for upper extremity and trunk support due to poor positioning which had worked well thus far for R26's positioning needs. The note also indicated R26's positioning would be monitored. The medical record included a letter sent to a family member by the licensed social worker (LSW) dated 6/3/13, which informed the family of the use of a restraint. The letter noted in order to keep R26 safe in her Rock-n-Go chair, the facility had to put a tray across her lap which prevented	F 221	In regards to R26, on 8/29/13, the lap tray was being removed at meal times. On 9/10/13, the Falls and Restraint Committee met. R15 care plan revised to remove lap tray from breakfast until 4 pm each day. A new lap tray ordered for R15 for better placement and fit. On 9/13/13, new lap tray received and implemented for R26. Falls and Restraint Committee which is comprised of social worker, physical therapy, occupational therapy and a registered nurse will meet weekly. The Committee will review each resident with a restraint. The committee will establish that all restraints being used are least restrictive, being used for the least amount of time and attempts made for reduction. A note will be written by the Committee containing this information. The Committee will review care plans and care guides to make sure corrections and changes have been made on the use of restraints.	9/24/13

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F 221	Continued From page 2 her from getting out of the chair and attempting to stand by herself. The LSW identified the lap tray as a restraint and asked the family member to consent to the use of the lap tray. The consent form was included in the medical record and signed on 6/10/13. The physician order dated 7/25/13, indicated an order for the lap tray to be placed on when R26 was in her Rock-n-Go chair for proper positioning. The current plan of care identified R26 was at risk for falls and directed staff to utilize the Rock-n-Go wheelchair with the lap tray. However, observations revealed the lap tray was not used in a least restrictive manner. On all days of the survey (8/26-27-28-29/13) R26 was observed to be sitting in the Rock-n-Go wheelchair with a lap tray (restraint) attached to the chair which prevented R26 from standing. On 8/26/13, at 5:15 p.m. R 26 was observed seated in the Rock-n-Go wheelchair with the lap tray on in front of the dining room table while staff sat next to her and assisted her with her evening meal. On 8/27/13, at 8:10 a.m. and 12:15 p.m. R26 was observed seated in the Rock-n-Go wheelchair with the lap tray on in front of the dining room table while staff sat next to her and assisted her with her meals. On 8/28/13, at 8:24 a.m. and again at 12:24 p.m. R26 was observed to be sitting in the Rock-n-Go wheelchair with the lap tray on in front of the dining room table while staff sat next to her and assisted her with her meals. On 8/28/13, at 1:35 p.m. the assistant director of nursing (ADON) stated facility staff could remove	F 221	DON, or designee, will audit Falls and Restraint Committee Minutes to establish that least restrictive, least amount of time, and attempts for reduction have been documented. This will be audited every week for two (2) months, then monthly for six (6) months. DON, or designee, will audit care plans with use of restraints to establish they are being used least amount of time, in the least restrictive way and care plans are being implemented correctly. This will be audited every week for two (2) months, then monthly for six (6) months.	

Received 10/1/13 LB

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F 221	Continued From page 3 the lap tray at meal times but the nursing assistants would have to sit with her and make sure the lap tray was put back on after the meal was over. On 8/28/13, at 1:53 p.m. registered nurse (RN)-A stated there was no reason why the restraint could not be removed during the meal times because staff were seated beside her at all times during the meal to assist her. On 8/29/13, at 8:38 a.m. the director of nursing (DON) stated R26's lap tray should have been released at every meal so it was least restrictive. The DON added she thought the staff were releasing it at meal time. The facility's policy for Physical/Chemical restraints dated 8/07, indicated the facility would not apply a restraint unless the need was determined through the assessment and ordered by the physician to treat the medical symptom of the resident. The order would specify the length of time and the circumstances under which the restraint was to be used.	F 221		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation	F 282	This plan and response to CMS 2567 regarding 483.20(k)(3)(ii) 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 282	Continued From page 4 services in accordance with each resident's written plan of care for 3 of 3 residents (R26, R49 and R20) who were identified to require ambulation assistance through the facility's restorative nursing program. Findings include: R26's plan of care (POC) updated 1/22/13, indicated R26 was weak and had difficulty walking due to the weakness and dementia. The POC directed staff to ambulate R26, 200 feet with a front wheeled walker (FWW), daily. R26's diagnoses included Alzheimer's disease, dementia with behavior disturbances and anxiety. The quarterly Minimum Data Set (MDS) dated 7/11/13, indicated R26 had a memory deficit with severely impaired decision making skills. The MDS also indicated R26 was totally dependent on two staff for transfers and mobility. The physical therapy (PT) progress note dated 4/19/12, indicated R26 was able to walk 200 feet with a FWW and required a restorative nursing plan for ambulation. On 8/28/13, at 9:44 a.m. R26 was observed seated in a Rock-n-Go wheelchair with a lap tray (restraint) attached to the chair which prevented R26 from standing. At this time Nursing assistant (NA)-B and NA-C was observed to wheel R26 into the bathroom, remove the lap tray and assisted R26 to a standing position. R26 was observed to stand and take a few steps before sitting down on the toilet. NA-B stated R26 walked in the hallway at times but also had a history of refusing to walk. NA-B added that	F 282	In regards to R26, R49 and R20, a walk to dine care plan was established on 9/10/13. They are being walked to evening meal by nursing assistant every evening. This is documented in the ADL charting each evening. A policy will be developed for Restorative Nursing to establish procedures for residents and staff to ensure residents receive restorative care consistently. Policy will be developed by nursing and therapy. Residents receiving restorative nursing will have care plans completed by the restorative aide or certified nursing assistant if the restorative aid is not available. A restorative to do list will be printed out by evening LPN. This list will be given to restorative aid or nursing assistant working days. The restorative care plans will be completed by designated staff. Care plans which have not been completed on day shift will be delegated to nursing assistants on evening shift to complete. The list will be turned into registered nurse the next day for review of completion.	9/30/13 10/9/13 10/9/13

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F 282	Continued From page 5 sometimes when R26 was acting restless, the staff walked with her and she responded well. Review of the Restorative Nursing Program sheets indicated the following: -In 5/13, out of 31 opportunities R26 was ambulated seven days, refused 12 times, and the other 12 days were blank. -In 6/13, out of 30 opportunities R26 was ambulated three days, refused seven times, and the other 17 days were blank. -In 7/13, out of 31 opportunities R26 was ambulated four days, refused seven times and the other 20 days were blank. -In 8/13, out of 28 opportunities R26 was ambulated two days and the other 26 days were blank. R49 was not provided ambulation assistance as directed by the POC. R49's POC updated 4/3/13, indicated R49 ambulated with a FWW and assist of two staff due to weakness from a stroke. The POC directed staff to ambulate R49, 400 feet with a FWW, daily. R49's diagnoses included cerebral vascular accident (stroke) with left sided weakness and depression. The quarterly MDS dated 6/26/13, indicated R49 had intact cognition and required the physical assistance of two staff for transfers, walking and	F 282	Restorative Nursing care will be documented in binder specifically for recording restorative care. Training will be held for LPN's, restorative aids, and certified nursing assistants on new procedure and policy for completing and maintaining restorative nursing care. DON, or designee, will audit restorative care plan and completion of the care plans every week for four (4) weeks, then every two (2) weeks for two (2) months, then every month for three (3) months.	10/9/13 9/30/13 10/1/13 10/8/13

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F 282	Continued From page 6 repositioning. The MDS also indicated R49 did not walk in his room and had walked in the hallway one time during the seven day assessment period. The PT progress note dated 10/17/12, indicated R49 was able to walk between 300 to 400 feet, with rest periods. The note instructed staff to place R49 on a restorative nursing plan for ambulation. On 8/27/13, at 11:15 a.m. R49 was observed to be sitting in a wheelchair with limitations to his left side. R49 stated he did not get to walk as much as he would like and that he used to walk a long ways every day when he lived at home. Review of the Restorative Nursing Program sheets indicated the following: -In 5/13, out of 31 opportunities R49 was ambulated 16 days, refused four times and the other 11 days were blank. -In 6/13, out of 30 opportunities R49 was ambulated 13 days and the other 17 days were blank. -In 7/13, out of 31 opportunities R49 was ambulated eight days, refused seven times and the other 16 days were blank. -In 8/13, out of 28 opportunities R49 was ambulated three days and the other 25 days were blank. R20 was not provided ambulation assistance as directed by the POC.	F 282		

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F 282	Continued From page 7	F 282		

R20's POC dated 8/29/13, directed staff to ambulate her with hand-hold assistance of one to two staff and to ensure R20 had appropriate shoes on for ambulation. The NA care sheet dated 8/29/13, noted R20 was to be ambulated 300 feet, with hand-hold assistance, from one to two NAs.

R20 diagnoses included Alzheimer's disease and depressive disorder.

The MDS dated 6/13/13, indicated R20 had severely impaired cognition and required limited assistance from two staff to walk in hallways.

On 8/29/13, at 8:23 a.m. restorative aide (RA)-A verified R20 should be ambulated daily. However, RA-A stated R20's ambulation was not being completed due to the rehab aides being pulled from rehab to do other tasks, therefore, they were not able to complete the rehab duties such as ambulation.

Review of the Restorative Nursing Program sheets indicated the following:

-In 6/13, R20 was ambulated 11 of 30 days, with two days documented as refused and nothing documented for the remaining days.

-In 7/13, R20 was ambulated nine of 31 days, with one day documented as refused and nothing documented for the remaining days.

-In 8/13, R20 was ambulated two of 29 days with one day documented as refused. RN-A documented in the nursing notes that she

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F 282	Continued From page 8 ambulated with R20 on one additional day in 8/13. Documentation for the remaining days was blank. On 8/28/13, at 1:53 p.m. registered nurse (RN)-A, supervisor of the rehabilitation program, verified the program was not being completed because of short staffing. RN-A stated the facility had two NA's working as rehab aides but they had been pulled to work on the floor. On 8/29/13, at 9:10 a.m. PT verified R26, R49 were not being ambulated according to their plan of care. On 8/29/13, at 9:35 a.m. NA-A verified she was one of the rehab aids but had not had time to complete the rehab program due to being pulled to work on the floor. NA-A added it had only been this way for the last few months. On 8/29/13, at 9:38 a.m. the director of nursing (DON) confirmed the facility's restorative nursing program was not fully implemented due to having to pull staff from the restorative program to work on the floor. The DON confirmed that resident ambulation POC's for R26, R49 and R20 were not being implemented.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 311	This plan and response to CMS 2567 regarding 483.25(a)(2) 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	

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F 311	Continued From page 9 Based on observation, interview and document review, the facility failed to provide ambulation services to improve or maintain each resident's ability to ambulate for 3 of 3 residents (R26, R49 and R20) who were assessed to require ambulation services. Findings include: R26's diagnoses included Alzheimer's disease, dementia with behavior disturbances and anxiety. The quarterly Minimum Data Set (MDS) dated 7/11/13, indicated R26 had memory loss, severely impaired decision making skills and was totally dependent on two staff for transfers and mobility. The Fall Risk Care Area Assessment (CAA) dated 4/23/13, indicated R26 was not able to stand, transfer or walk without assistance. The physical therapy (PT) progress note dated 4/19/12, indicated R26 was able to walk 200 feet with a front wheeled walker (FWW) and required a restorative nursing plan for ambulation. R26's plan of care (POC) updated 1/22/13, indicated R26 was weak and had difficulty walking due to the weakness and dementia. The POC directed staff to ambulate R26 200 feet with a FWW, daily. On 8/28/13, at 9:44 a.m. R26 was observed seated in a Rock-n-Go wheelchair with a lap tray (restraint) attached to the chair which prevented R26 from standing. At this time Nursing assistant (NA)-B and NA-C was observed to wheel R26 into the bathroom, remove the lap tray and assisted R26 to a standing position. R26 was observed to stand and take a few steps before	F 311	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. In regards to R26, R49 and R20, a walk to dine care plan was established on 9/10/13. They are being walked to evening meal by nursing assistant every evening. This is documented in the ADL charting each evening. A policy will be developed for Restorative Nursing to establish procedures for residents and staff to ensure residents receive restorative care consistently. Policy will be developed by nursing and therapy. 9/30/13 Residents receiving restorative nursing will have care plans completed by the restorative aid or certified nursing assistant, if the restorative aid is not available. 10/9/13 A restorative to do list will be printed out by evening LPN. The list will be given to restorative aid or nursing assistant working days. The restorative care plans will be completed by designated staff. Care	

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F 311	Continued From page 10 sitting down on the toilet. NA-B stated R26 walked in the hallway at times but also had a history of refusing to walk. NA-B added that sometimes when R26 was acting restless, the staff walked with her and she responded well. Review of the Restorative Nursing Program sheets indicated the following: -In 5/13, out of 31 opportunities R26 was ambulated seven days, refused 12 times, and the other 12 days were blank. -In 6/13, out of 30 opportunities R26 was ambulated three days, refused seven times, and the other 17 days were blank. -In 7/13, out of 31 opportunities R26 was ambulated four days, refused seven times and the other 20 days were blank. -In 8/13, out of 28 opportunities R26 was ambulated two days and the other 26 days were blank. The Restorative Nursing Program sheets also indicated R26 ambulated approximatly 10-200 with each opportunity provided, respectively. R49 was not provided ambulation assistance as directed the POC. R49's diagnosis included a cerebral vascular accident (stroke) with left sided weakness and depression. The quarterly MDS dated 6/26/13, indicated R49	F 311	plans which have not been completed on the day shift will be delegated to nursing aid on the evening shift to complete. The list will be turned into registered nurse the next day for review of completion. Restorative nursing care will be documented in binder specifically for recording restorative care. Training will be held for LPN's, restorative aides, and nursing assistants on new procedures and policy for completing and maintaining restorative nursing care. DON, or designee will audit restorative care plans and completion of the care plans every week for four (4) weeks then every two (2) weeks for two (2) months, then every month for three (3) months. RN review of restorative nursing care plans will be done monthly and goals/plans will be changed as needed based on residents' performance.	10/9/13 10/9/13 9/30/13 10/1/13 10/8/13 10/9/13

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F 311	Continued From page 11 had intact cognition and required physical assistance of two staff for transfers, walking and repositioning. The MDS also indicated R49 had walked in the hallway one time during the seven day assessment period. The Activities of Daily Living (ADL) CAA dated 10/15/12, indicated R49 was not able function independently due to limitations and required help with all ADLs. The PT progress note dated 10/17/12, indicated R49 was able to walk between 300 to 400 feet, with rest periods. The note instructed for R49 to be placed on a restorative nursing plan for ambulation. The POC updated 4/3/13, indicated R49 ambulated with a FWW and assist of two staff due to weakness. The POC directed staff to ambulate R49, 400 feet with FWW, daily. On 8/27/13, at 11:15 a.m. R49 was observed seated in a wheelchair with limitations to his left side. R49 stated he did not get to walk as much as he would like and that he used to walk a long ways every day when he lived at home. Review of the Restorative Nursing Program sheets indicated the following: -In 5/13, out of 31 opportunities R49 was ambulated 16 days, refused four times and the other 11 days were blank. -In 6/13, out of 30 opportunities R49 was ambulated 13 days and the other 17 days were blank. -In 7/13, out of 31 opportunities R49 was ambulated eight days, refused seven times and	F 311	DON or designee will audit restorative care plans to make sure goals/plans are current and functional. This audit will happen every month for six (6) months.	

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	245542	A. BUILDING _____ B. WING _____	08/29/2013

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F 311	Continued From page 12 the other 16 days were blank. -In 8/13, out of 28 opportunities R49 was ambulated three days and the other 25 days were blank. The Restorative Nursing Program sheet also indicated R49 ambulated 135-552 feet with each opportunity provided, respectively. R20 had diagnoses of Alzheimer's disease and depressive disorder. The MDS dated 6/13/13, indicated R20 had severely impaired cognition and required limited assistance from two staff to walk in hallways. The PT progress note dated 10/12/12, indicated R20 continued to do well with ambulation therefore, R20 was placed on the restorative nursing program on 10/10/12. The note indicated R20 walked fast and leaned forward. The note also indicated R20 was not safe to walk independently as she lost her balance and also attempted to sit down randomly because she was used to using a Merry Walker (a four wheeled walker/ wheelchair that enclosed the resident between the four wheels for balance stability). R20's POC dated 8/29/13, instructed staff to ambulate her with hand-hold assistance of one to two and to ensure appropriate shoes were worn for ambulation. The NA care sheet dated 8/29/13, indicated R20 was to be ambulated 300 feet, with hand-hold assistance of one to two NAs. Review of the Restorative Nursing Program	F 311		

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F 311	Continued From page 13 sheets indicated the following: -In 6/13, R20 was ambulated 11 of 30 days, with two days documented as refused and nothing documented for the remaining days. -In 7/13, R20 was ambulated nine of 31 days, with one day documented as refused and nothing documented for the remaining days. -In 8/13, R20 was ambulated two of 29 days with one day documented as refused. RN-A documented in the nursing notes that she ambulated with R20 on one additional day in 8/13. Documentation for the remaining days was blank. The Restorative Nursing Program sheets also indicated R20 ambulated 40-347 feet with each opportunity provided, respectively. On 8/28/13, at 1:53 p.m. registered nurse (RN)-A, supervisor of the rehabilitation program, verified the program was not being completed due to short staffing in which staff were required to prioritize work needs. RN-A stated the facility had two NA's working as rehab aides but they had been pulled to work on the floor. On 8/29/13, at 8:23 a.m. restorative aide (RA)-A verified R20 should be ambulated daily. However, RA-A stated R20 was not ambulated daily due to the rehab aides being pulled from rehab services for other tasks and unable to complete rehab duties. On 8/29/13, at 9:10 a.m. the PT verified R26 and R49 were not being ambulated according to their POC. The PT stated had R49's ambulation	F 311		

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F 311	Continued From page 14 program would have been beneficial had it been fully implemented. The PT stated the lack of follow through with the ambulation programs was due to being short of staff. On 8/29/13, at 9:35 a.m. RN-A verified R20 had been ambulating independently with a Merry Walker which had been discontinued due to safety concern. RN-A verified that R20 should have been ambulated daily and was not. On 8/29/13, at 9:35 a.m. NA-A verified she was one of the rehab aids but had not had time to complete the rehab program due to being pulled to work on the floor. NA-A added it had only been this way for the last few months. On 8/29/13, at 9:38 a.m. the director of nursing (DON) confirmed the facility's restorative nursing program was not being fully implemented due to having to pull staff from the restorative program to work on the floor. The DON indicated the facility had recently been able to hire more staff. The facility did not provide a policy related to the restorative nursing program.	F 311		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	This plan and response to CMS 2567 regarding 483.60(b), (d), (e) 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	

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F 431	Continued From page 15 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to establish a system that was consistent with current standards of practice for the disposal of controlled substances within the facility for 3 of 3 residents (R1, R10, R68) with prescribed Fentanyl transdermal patches. Findings include: During medication administration observations on 8/27/13, at 9:24 a.m. licensed practical nurse	F 431	any non-compliance with this regulation exists, we have instituted the following measures. In regards to R10, R1, R68, their medication administration records have a space for verification of used Fentanyl patch destruction. This is being signed off by two nurses on the record. Implemented 8/29/13. A policy was created for destruction of used fentanyl patches. The policy was faxed to consulting pharmacist for review. The policy will be reviewed with Pharmacy and Therapeutic Committee at the next meeting. DON, or designee, will audit destruction of used fentanyl patches every week for one (1) month, then every two (2) weeks for two (2) months, then every month for four (4) months.	8/29/13 9/17/13 9/18/13 10/2013 10/9/13 SB

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F 431	Continued From page 16 (LPN)-A stated two staff members were to witness the disposal of Fentanyl patches down the city sewer. However, LPN-A stated neither nurse documented the disposal of the patches in order to verify this process. Review of the narcotic log book revealed the lack of documentation verifying the disposal of the Fentanyl patches. R1's diagnosis included osteoarthritis. R1's Physician Orders form dated August 2013, indicated a Fentanyl 25 microgram (mcg) per hour (hr) transdermal patch to be applied every 72 hours. R10's diagnoses included leg and shoulder joint pain and shoulder rotator cuff syndrome. R10's Physician's Orders form dated August 2013, indicated Fentanyl 150 mcg/hr transdermal patch be applied every 72 hours. R68's diagnosis included spinal stenosis. R68's Physician's Order form dated August 2013, indicated Fentanyl 25 mcg/hr transdermal patch to be applied every 72 hours. On 8/27/13, at 12:02 p.m. registered nurse (RN)-A verified two licensed staff were to observe the disposal of the Fentanyl patches down the city sewer. RN-A confirmed the facility did not require the staff to document the disposal. On 8/27/13, at 2:09 p.m. LPN-B stated R1, R10 and R68 received the application of the Fentanyl patches. LPN-B verified licensed staff had not documented the disposal of the Fentanyl patches. On 8/27/13, at 2:14 p.m. LPN-A was observed to	F 431		

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F 431	Continued From page 17 dispose of a Fentanyl patch down the city sewer. The director of nursing (DON) witnessed the destruction. LPN-A nor the DON documented the disposal. On 8/27/13, at 2:19 p.m. the DON verified the use of Fentanyl patches in the facility and stated she was unaware of the need to have staff document the destruction of the Fentanyl patches. The DON stated the facility lacked a policy and procedure related the disposal of controlled substances. Additionally, the DON confirmed the lack of staff documentation confirming the disposal of the Fentanyl patches. On 8/28/13, at 9:42 a.m. the facility consulting pharmacist verified the risk of medication diversion related to the use of Fentanyl patches, however,. stated she was unaware of the need to have two staff document the destruction of the patches. The consulting pharmacist also verified the facility did not have a policy and procedure related to the destruction of the Fentanyl patches.	F 431		
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	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 18 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 interview and document review, the facility's infection control program lacked a surveillance program which included information related to infections, organisms and antibiotics. The infection control program also failed to include tracking and analysis of the data collected to determine interventions to prevent the spread of infections. This had the potential to effect all 47 of 47 residents who resided in the facility. Findings include:	F 441	Infection control nurse will meet with DON at Bigfork Valley to begin establishing policies and procedures. Received Infection Control Resource Manual Obtained a lock box in which to deposit forms for staff illness Developed a policy for Employee Absence Due to Illness Developed a policy for Tracking and Recording Resident Infections. Obtained maps of facility and dining room showing resident placement and living arrangements so infections could be tracked. Wrote and posted memo for department heads and all employees about new policy for reporting illness Development forms for recoding, tracking and investigating staff absence due to illness.	9/4/13 9/11/13 9/12/13 9/13/13 9/13/13 9/18/13 9/18/13 9/18/13

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F 441	Continued From page 19 The quarterly infection control reports for 7/12 to 6/13, were provided by the infection control registered nurse (RN)-A. The reports tracked resident names and the type of infection, but did not indicate resident room locations, the type of organism responsible for the infection, and whether the antibiotic was effective. Also, no analysis of this data was included to identify patterns and to determine what staff education, environmental interventions, or isolation was necessary to minimize the spread of infections. RN-A stated she was informed of infections at morning report and documented the infections in a quarterly summary report that was presented to the quality assurance committee. RN-A verified she did not have any recorded data showing clearly what the infectious organism was, how it was acquired or whether the antibiotic was effective. RN-A further stated there was no documentation to evidence trending or tracking had been completed and there was no facility policy for a surveillance program. During review of the employee surveillance program, RN-A stated that each individual department kept a call-in log for employee illness/infections. The individual departments kept the call-in logs until the end of the month, at which time they were given to the infection control nurse for review. RN-A stated there were employee call-ins in 7/13, but had no written documentation to evidence logging of employee infections or symptoms. RN-A verified the employee surveillance program "was not good," and that it lacked the appropriate documentation. An employee illness surveillance policy was requested and none was provided. On 8/29/13, at 11:03 a.m. the director of nursing (DON) verified the infection control program	F 441	Developed forms for recording monthly resident infections which will be used to track, investigate, plot and review infections and treatments. Infection control nurse will evaluate forms twice weekly to identify patterns and effectiveness of interventions. 47 out of 47 residents will have an Infection Control program which identifies, tracks, plots and evaluates trends in infections and interventions by 9/23/13 Infection Control Nurse will provide a quarterly report to the infection control and quality assurance committees which will include a summary of employee and resident infection trends. This will begin at next quarterly meetings in October 2013, and each quarter thereafter. Staff meeting for review of infection control policies and procedures for staff (LPN and CNA's). Starting in October 2013, DON or designee will audit infection control procedures and policies every week for 2 months, then every third week of the month for six months.	9/20/13 9/23/13 9/23/13 9/30/13 10/1/13 10/8/13

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F 441	Continued From page 20 lacked the required components related to the surveillance for residents and staff.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain resident bathroom flooring and toilet seal caulking in clean and sanitary conditions for 14 of 31 resident bathrooms. In addition, the facility failed to ensure 1 of 1 hand washing sinks in the kitchen was clean. Findings include: During the environmental tour on 8/28/13, at 8:28 a.m. with the environmental services director (ESD) the following was observed: North Wing: Room #1: the bathroom flooring and caulking around the toilet was stained gold and black. The ESD stated both needed to be replaced. Room #2: The bathroom flooring and caulking around the toilet was stained blackish-gray color and dirty. Room #5: The bathroom floor and caulking around the toilet was stained blackish-gray in	F 465	This plan and response to CMS 2567 regarding 465.70(h) 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. Room #1: The bathroom flooring was striped, deep cleaned to be free of stains, sealed and waxed. The caulking around the toilet was removed and replaced. 9/20/13. Room #2: The bathroom flooring was striped and deep cleaned to be free of stains, sealed and waxed. The caulking around the toiled was removed and replaced. 9/20/13. Room #5: The bathroom flooring was striped and deep cleaned to be free of stains sealed and waxed the caulking around the toiled was removed and replaced. 9/19/13.	9/20/13 9/20/13 9/19/13

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F 465	Continued From page 21 sporadic areas and dirty. Room #7: The flooring tile had sporadic stained black-gray areas. Room #13: The bathroom floor molding was observed separating from the tiles leaving uncleanable surface gaps. Room #14: The bathroom flooring was stained with uncleanable areas. Room #15: The caulking around the toilet was dirty and stained. The ESD stated it needed to be replaced. East Wing: Room #24: The bathroom flooring was stained and had dirt around the edges and built up in the corners of the room. Room #28: The bathroom flooring was observed missing chunks of tile where-as the tile was separating leaving uncleanable gaps in the flooring. The caulking around the toilet seat was also observed stained and uncleanable. Room #29: The bathroom flooring was stained black-gray color in sporadic areas. Room #30: The bathroom flooring was observed stained, uncleanable. Room #31: The caulking around the toilet was observed stained and uncleanable. The ESD stated it needed to be replaced. Room #33: The bathroom floor grouting stained	F 465	Room #7: The bathroom flooring was striped and deep cleaned to be free of stains, sealed and waxed. The caulking around the toiled was removed and replaced. 9/18/13.	9/18/13
			Room #13: The bathroom floor molding was repaired. The flooring was striped and deep cleaned, sealed and waxed. The caulking around the toilet was removed and replaced. 9/18/13	9/18/13
			Room #14: The bathroom flooring was striped and deep cleaned to be free of stains, sealed and waxed. The caulking around the toilet was removed and replaced. 9/17/13	9/17/13
			Room # 15: The bathroom flooring was striped and deep cleaned to be free of stains, sealed and waxed. The caulking around the toilet was removed and replaced. 9/17/13	9/17/13
			Room #28: The bathroom flooring was repaired, striped and deep cleaned, to be free of stains, sealed and waxed. The caulking around the toiled was removed and replaced. 9/16/13	9/16/13

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F 465	Continued From page 22 and the ESD stated it needed to be replaced. Room #34: The caulking around the toilet was dirty, stained and uncleanable. Throughout the tour the ESD verified the findings and stated it was an old building and it was difficult to get cleaning equipment / machines into the bathrooms to clean. However, the ESD stated the bathroom floors were sanitized daily. In addition, the ESD verified the identified bathroom flooring and caulking around the toilets was uncleanable and stated they needed to be replaced. A policy related to floor care / cleaning and caulking was requested and not provided. On 8/28/13, at 9:02 a.m. the hand washing sink located in the main kitchen was observed to have a light brown, removable coating in the bottom of the sink. In addition, there were light brown stains inside the sink. The top ledge of the sink had removable dust/dirt debris on it. At 9:28 a.m. the certified dietary manager (CDM) verified the sink was dirty. Dietary aide (DA)-A stated the sink was not on a cleaning schedule. A policy was requested and none was provided. On 8/27/13, at 8:20 a.m. housekeeper-A was observed in R49's room sweeping the floor. The housekeeper verified the grouting around the toilet was dirty, stained and looked bad. Housekeeper-A also stated it had been reported to maintenance that it needed to be replaced but nothing was done about it. The housekeeper added, maintenance cleaned the bathroom floors and stated they are dirty and stained, some of the corners just need to have a brush taken to them.	F 465	Room #29: The bathroom flooring was striped, deep cleaned to be free of stains, sealed and waxed. The caulking was removed and replaced. 9/16/13. Room #30: The bathroom flooring striped, deep cleaned to be free of stains, sealed and waxed. The caulking was removed and replaced. 9/16/13. Room # 31: The caulking around the toilet was removed and replaced. The bathroom flooring was striped and deep cleaned to be free of stains, sealed and waxed. 9/13/13. Room # 33: The bathroom floor and grouting was striped and deep cleaned to be free of stains, sealed and waxed. 9/13/13. Room # 34: The caulking around the toiled was removed and replaced. 9/12/13.	9/16/13 9/16/13 9/13/13 9/13/13 9/12/13

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 _____	08/29/2013

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
			The Housekeeping Department will deep clean the bathrooms in the nursing home paying special attention to the flooring, grout, molding, and caulking around the toilets and report any cracks, loose or damaged floor molding and stained caulking around the toilets to the Environmental Services Director to schedule repairs or replacement. Audits of nursing home resident bathrooms cleanliness, stains, grouting and caulking condition, will be performed weekly for two (2) months bi-weekly for two (2) months and monthly for four (4) months.	

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 _____	**08/27/2013**

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 Surveyor: 03006 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 not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person	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 _____	**08/27/2013**

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	Continued From page 1 responsible for correction and monitoring to prevent a reoccurrence of the deficiency 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. 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		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7012

September 11, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5542022

Dear Mr.. Anderson:

The above facility was surveyed on August 26, 2013 through August 29, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5542010. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, Lyla Burkman, Minnesota Department of Health, 705 5th St. NW, Suite A, Bemidji, MN 56601. 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 me.

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 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.

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File