DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 25, 2025

Administrator
LITTLEFORK CARE CENTER
912 MAIN STREET
LITTLEFORK, MN 56653

RE: CCN: 245542
Cycle Start Date: February 20, 2025

Dear Administrator:

On March 12, 2025, we notified you a remedy was imposed. On May 13, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 12, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective March 27, 2025 be discontinued as of May 12, 2025. (42 CFR 488.417 (b))

In our letter of March 12, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 27, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 12, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: February 20, 2025

Dear Administrator:

On February 27, 2025, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 26, 2025, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 27, 2025.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 27, 2025,(42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 27, 2025,(42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 27, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Littlefork Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 27, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 20, 2025 (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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 On 2/19/25 through 2/20/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H55426481C (MN00110302), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to perform a comprehensive assessment of falls to include	F 689	R2 has had no additional falls since 2/11/25. A wider bed was ordered for R2 on 3/10/25. RN Case Manager to update	3/31/25

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

Electronically Signed | 03/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 1 root cause and failed to implement appropriate interventions to reduce the risk for falls from bed for 1 of 3 residents (R2) reviewed who had multiple falls from bed. Findings include: R2's Admission Record indicated he admitted to the facility 5/6/24. R2's diagnosis included Alzheimer's disease, hemiplegia (severe or complete loss of movement function) and hemiparesis (mild to moderate weakness), dementia and insomnia. R2's quarterly Minimum Data Set (MDS) dated 12/31/24, identified moderate cognitive impairment and indicated no hallucinations, delusions or behaviors were displayed. The MDS indicated R2 had upper and lower extremity impairments to one side and indicated he was independent with transfers and ambulation. R2's MDS indicated frequent bladder incontinence and occasional bowel incontinence and indicated he had two or more falls since the previous assessment. R2's care plan dated 1/9/25, identified a risk for falls related to confusion, incontinence, and a lack of awareness of safety needs. Interventions initiated 11/20/24, included staff to assist as needed with mobility and transfers, ensure call light in reach, provide a call, do not fall sign, non-skid strips on the floor and ensure appropriate footwear. The care plan further indicated R2 was close to the nurse's station for monitoring, added 1/9/25 and tape on the wall to determine appropriate bed height on 1/7/25. An untitled document indicated IDT reviewed falls on 11/26/24, R2 had already been moved closer to	F 689	care plan with new fall intervention. DON will educate nursing staff on new intervention of wider bed. All residents at risk for falls within the facility could potentially be impacted by this deficient practice. Fall Prevention and Management Policy was reviewed by the DON on 03/10/2025 with no changes needed. DON will educate the RN Case Managers, ADON, and Fall Preventionist on the Fall Prevention and Management policy, that comprehensive assessment of falls are to include a root cause, and interventions are to be implemented based on the root cause. DON or designee will audit residents' electronic health records for documentation that a fall analysis is being conducted per care center policy (2 or more falls), documentation identifies if any trends, root cause of fall(s) is identified, interventions are implemented based on the root cause, and current interventions are evaluated for effectiveness. Audits will be performed 3X/week X2weeks, then 2X/week X 2weeks, then once weekly thereafter beginning the week of 3/17/25. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 2	F 689		

the nurse's station and indicated tape on the wall for bed height. The care plan further identified bowel incontinence and directed staff to check every two hours and assist with toileting as needed, added 11/19/24 and bladder incontinence, change every 2-3 hours, added 11/19/24.

A review of R2's Fall reports, Progress Notes and correlating interdisciplinary team (IDT) reviews indicated the following:

11/6/24 at 11:20 p.m., Staff heard R2 yelling and found him on the floor on the right side of the bed. R2 denied feeling short of breath or feeling dizzy or lightheaded. IDT action indicated, educate R2 on call light use and to sit for five minutes before standing.

11/10/24 at 11:25 p.m., R2 was found lying on his left side on the floor next to his bed. R2 had gripper sock on and had one shoe on. R2 sustained skin tears to his right hand. IDT action indicated to make sure his shoes were on properly.

11/17/24 at 4:45 a.m., staff found R2 on the floor next to his bed. Potential root cause indicated foam mattress pad. IDT action included moving R2 closer to the nursing station.

11/30/24 at 11:30 p.m., staff found R2 sitting on the floor next to his bed. It appeared he had slid out of bed. IDT action indicated room check by staff walking by and started on Trazadone (an antidepressant that is sometimes prescribed as a sleep aid) to promote sleep.

12/14/24 at 4:04 a.m., staff found R2 laying on

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 _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 3 the floor next to his bed. 1/3/25 at 9:47 p.m., staff found R2 sliding off the edge of his bed. Progress Note dated 1/4/25, indicated R2 was trying to get up and slid off the bed. The note indicated it was a common occurrence as R2 often sat too close to the edge of the bed. 1/29/25 at 5:44 p.m., R2 fell ambulating in the hallway. 1/30/25 at 9:33 p.m., R2 was found on the floor next to his bed. R2 stated he fell out of bed. 2/11/25 at 3:45 p.m. staff found R2 kneeling in front of his bed. R2 stated he slid out of bed. An untitled document indicated IDT. The document indicated reviewed the falls that occurred 1/29/25, 1/30/25 and 2/11/25, on 2/11/25. Care plan was reviewed and follow up in one week with physical therapy evaluation. 2/11/25- IDT reviewed falls on 1/29, 1/30 and 2/11- Has been more unsteady, weaker with a significant change to be conducted. Has dementia and does not realize he needs assistance with transfers and toileting. R2's Bowel and Bladder Comprehensive assessment dated 2/18/25, indicated he was able to call for assistance to use the toilet. The assessment indicated R2 was always incontinent of bladder and bowel and required extensive assist to total dependence for all transfers and had impaired mobility. The assessment indicated a recent decline in mobility and with this there had been a noted increase in incontinence.	F 689		

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 _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 4 R2's Fall Comprehensive assessment dated 2/19/25, indicated he sustained three or more falls since the previous assessment, had difficulty maintaining balance and identified gait problems. The assessment identified a high risk for falls and indicated he ambulated with assistance and at times transferred with assistance of a mechanical stand device. During observation on 2/19/25 at 12:15 p.m. R2 was seated at a table in the dining room wearing white socks that appeared to have nonslip circles on the bottom. During observation of R2's room at 1:54 p.m. grip strips were observed on the floor in front of the bed and the toilet. Signs that read, call do not fall were observed across from the bed on the wall by the entrance to the bathroom. During interview on 2/19/25 at 2:09 p.m. nursing assistant (NA)-A stated R2 "basically slides out of bed." NA-A said R2 slept perpendicular on his bed and used to walk independently but did not anymore. During interview on 2/19/25 at 2:21 p.m., registered nurse (RN)-A stated R2 had a diagnosis of Alzheimer's and was very impulsive and wants to do what he wants to do. RN-A said R2 had impairments to his right side and when he tried to get up too fast, he tripped on the bed. RN-A said R2 laid on the bed with is bottom half hanging off and said that was the reason for many of his falls. During interview on 2/19/25 at 3:35 p.m., the director of nursing (DON) stated after a fall the IDT members reviewed the falls and completed an analysis of the fall to determine root cause and put interventions in place based on the cause.	F 689		

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 _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 5 The DON stated they had identified most of R2's falls occurred late at night and early morning and said they had implemented interventions that included closer supervision, room near the nurse's station and said recently R2 had been ill and had started to fall again. During interview on 2/20/25 at 11:00 a.m. The DON, assistant director of nursing (ADON) and RN-B were interviewed. The ADON said at one time they had physical therapy adjust the height of the bed and place tape on the wall and applied grip strips to the floor. The ADON said R2 had mobility issues and had some increased weakness and would slide off the bed. The ADON also said R2 laid sideways on the bed. The ADON said a physical therapy evaluation had been done last week but she had not seen it yet. ADON stated the fall interventions should still be appropriate and said it was hard to find new interventions. Facility Policy Fall Prevention and Management dated 6/5/23, indicated a falls analysis will be completed when a resident has two or more falls, to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. The IDT will systematically review the fall and interventions put into place to determine their effectiveness. If an intervention is not effective or appropriate to the root cause, new interventions will be developed and implemented.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

Re: State Nursing Home Licensing Orders
Event ID: TMCC11

Dear Administrator:

The above facility was surveyed on February 24, 2025 through February 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/19/25 through 2/20/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed: H55426481C (MN00110302) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 000	Continued From page 2 state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to perform a comprehensive assessment of falls to include root cause and failed to implement appropriate interventions to reduce the risk for falls from bed for 1 of 3 residents (R2) reviewed who had multiple falls from bed. Findings include: R2's Admission Record indicated he admitted to	2 830	corrected	3/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 3 the facility 5/6/24. R2's diagnosis included Alzheimer's disease, hemiplegia (severe or complete loss of movement function) and hemiparesis (mild to moderate weakness), dementia and insomnia. R2's quarterly Minimum Data Set (MDS) dated 12/31/24, identified moderate cognitive impairment and indicated no hallucinations, delusions or behaviors were displayed. The MDS indicated R2 had upper and lower extremity impairments to one side and indicated he was independent with transfers and ambulation. R2's MDS indicated frequent bladder incontinence and occasional bowel incontinence and indicated he had two or more falls since the previous assessment. R2's care plan dated 1/9/25, identified a risk for falls related to confusion, incontinence, and a lack of awareness of safety needs. Interventions initiated 11/20/24, included staff to assist as needed with mobility and transfers, ensure call light in reach, provide a call, do not fall sign, non-skid strips on the floor and ensure appropriate footwear. The care plan further indicated R2 was close to the nurse's station for monitoring, added 1/9/25 and tape on the wall to determine appropriate bed height on 1/7/25. An untitled document indicated IDT reviewed falls on 11/26/24, R2 had already been moved closer to the nurse's station and indicated tape on the wall for bed height. The care plan further identified bowel incontinence and directed staff to check every two hours and assist with toileting as needed, added 11/19/24 and bladder incontinence, change every 2-3 hours, added 11/19/24. A review of R2's Fall reports, Progress Notes and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 4 correlating interdisciplinary team (IDT) reviews indicated the following: 11/6/24 at 11:20 p.m., Staff heard R2 yelling and found him on the floor on the right side of the bed. R2 denied feeling short of breath or feeling dizzy or lightheaded. IDT action indicated, educate R2 on call light use and to sit for five minutes before standing. 11/10/24 at 11:25 p.m., R2 was found lying on his left side on the floor next to his bed. R2 had gripper sock on and had one shoe on. R2 sustained skin tears to his right hand. IDT action indicated to make sure his shoes were on properly. 11/17/24 at 4:45 a.m., staff found R2 on the floor next to his bed. Potential root cause indicated foam mattress pad. IDT action included moving R2 closer to the nursing station. 11/30/24 at 11:30 p.m., staff found R2 sitting on the floor next to his bed. It appeared he had slid out of bed. IDT action indicated room check by staff walking by and started on Trazadone (an antidepressant that is sometimes prescribed as a sleep aid) to promote sleep. 12/14/24 at 4:04 a.m., staff found R2 laying on the floor next to his bed. 1/3/25 at 9:47 p.m., staff found R2 sliding off the edge of his bed. Progress Note dated 1/4/25, indicated R2 was trying to get up and slid off the bed. The note indicated it was a common occurrence as R2 often sat too close to the edge of the bed. 1/29/25 at 5:44 p.m., R2 fell ambulating in the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 5 hallway. 1/30/25 at 9:33 p.m., R2 was found on the floor next to his bed. R2 stated he fell out of bed. 2/11/25 at 3:45 p.m. staff found R2 kneeling in front of his bed. R2 stated he slid out of bed. An untitled document indicated IDT. The document indicated reviewed the falls that occurred 1/29/25, 1/30/25 and 2/11/25, on 2/11/25. Care plan was reviewed and follow up in one week with physical therapy evaluation. 2/11/25- IDT reviewed falls on 1/29, 1/30 and 2/11- Has been more unsteady, weaker with a significant change to be conducted. Has dementia and does not realize he needs assistance with transfers and toileting. R2's Bowel and Bladder Comprehensive assessment dated 2/18/25, indicated he was able to call for assistance to use the toilet. The assessment indicated R2 was always incontinent of bladder and bowel and required extensive assist to total dependence for all transfers and had impaired mobility. The assessment indicated a recent decline in mobility and with this there had been a noted increase in incontinence. R2's Fall Comprehensive assessment dated 2/19/25, indicated he sustained three or more falls since the previous assessment, had difficulty maintaining balance and identified gait problems. The assessment identified a high risk for falls and indicated he ambulated with assistance and at times transferred with assistance of a mechanical stand device. During observation on 2/19/25 at 12:15 p.m. R2 was seated at a table in the dining room wearing	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 6 white socks that appeared to have nonslip circles on the bottom. During observation of R2's room at 1:54 p.m. grip strips were observed on the floor in front of the bed and the toilet. Signs that read, call do not fall were observed across from the bed on the wall by the entrance to the bathroom. During interview on 2/19/25 at 2:09 p.m. nursing assistant (NA)-A stated R2 "basically slides out of bed." NA-A said R2 slept perpendicular on his bed and used to walk independently but did not anymore. During interview on 2/19/25 at 2:21 p.m., registered nurse (RN)-A stated R2 had a diagnosis of Alzheimer's and was very impulsive and wants to do what he wants to do. RN-A said R2 had impairments to his right side and when he tried to get up too fast, he tripped on the bed. RN-A said R2 laid on the bed with is bottom half hanging off and said that was the reason for many of his falls. During interview on 2/19/25 at 3:35 p.m., the director of nursing (DON) stated after a fall the IDT members reviewed the falls and completed an analysis of the fall to determine root cause and put interventions in place based on the cause. The DON stated they had identified most of R2's falls occurred late at night and early morning and said they had implemented interventions that included closer supervision, room near the nurse's station and said recently R2 had been ill and had started to fall again. During interview on 2/20/25 at 11:00 a.m. The DON, assistant director of nursing (ADON) and RN-B were interviewed. The ADON said at one time they had physical therapy adjust the height of the bed and place tape on the wall and applied	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 7 grip strips to the floor. The ADON said R2 had mobility issues and had some increased weakness and would slide off the bed. The ADON also said R2 laid sideways on the bed. The ADON said a physical therapy evaluation had been done last week but she had not seen it yet. ADON stated the fall interventions should still be appropriate and said it was hard to find new interventions. Facility Policy Fall Prevention and Management dated 6/5/23, indicated a falls analysis will be completed when a resident has two or more falls, to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. The IDT will systematically review the fall and interventions put into place to determine their effectiveness. If an intervention is not effective or appropriate to the root cause, new interventions will be developed and implemented. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: February 20, 2025

Dear Administrator:

On March 12, 2025, we informed you of imposed enforcement remedies.

On April 25, 2025, the Minnesota Department of Health completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found 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 electronically attached CMS-2567, whereby corrections are required.

The deficiencies not corrected are as follows:

F657 -- S/S: D -- 483.21(b)(2)(i)-(iii) -- Care Plan Timing And Revision
F880 -- S/S: F -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control
F883 -- S/S: D -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations

As a result of the revisit findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), is effective March 27, 2025.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 27, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 27, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of March 12, 2025, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 27, 2025.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor

Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 20, 2025 (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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information

Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citations arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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
{E 000}	Initial Comments No deficiencies were issues at Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, CFR §483.73, at the time of the standard recertification survey, exited on 2/27/25.	{E 000}		
{F 000}	INITIAL COMMENTS On 4/21/25 through 4/24/25, an onsite site revisit was conducted to follow up on deficiencies related to a standard recertification survey exited on 2/27/24. The facility was NOT IN compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	{F 657}		5/12/25

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

Electronically Signed | 05/05/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 657}	Continued From page 1 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure care plan interventions were care planned according to assessments for 2 of 3 resident (R7, R38) reviewed for trauma informed care. Findings include: R7: R7's significant change Minimum Data Set (MDS) dated 3/5/25, identified R7 had post-traumatic stress disorder and sometimes displayed behaviors of social isolation. R7's Trauma-Informed Care (TIC) assessment dated 3/5/25, identified R7 was involved in a	{F 657}	R7 and R38 trauma care plans will be updated by the Social Services Director to identify personalized triggers and interventions related to their Trauma Informed Care Assessment. All residents that have experienced past traumatic events have the potential to be affected by this deficient practice. DON reviewed the Person-Centered Care Planning policy and Trauma Informed Care policy on 05/02/2025 with no changes needed. Social Services Director will review all current residents' Trauma Informed Care assessments to ensure all interventions are care planned, and if they are not, the	

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 657}	Continued From page 2 situation in which they were seriously injured or had been in a situation in which they feared they might be seriously injured or killed. R7 reported the situations included growing up in a violent home, felt their life didn't have purpose, and was involved in an attempted sexual assault. The assessment identified R7 reported interventions that helped included yelling to defend self, talking to someone that listened (including counselor, family or friend), and coloring. R7's care plan revised 3/13/25, failed to identify the TIC interventions identified on the TIC assessment dated 3/5/25. R38: R38's admission MDS dated 2/21/25, identified R38 had diagnoses including insomnia and adult failure to thrive. The assessment identified during the 14 day look back period, R38 reported feeling the following: - 2-6 days had little interest or pleasure in doing things; had trouble concentrating on things, such as reading or watching tv. - 7-11 days had trouble falling or staying asleep, or sleeping too much; had thoughts that resident would be better off dead, or of hurting self in some way. - 12-14 days felt down, depressed, or hopeless; felt bad about self - or that resident was a failure or had let yourself or your family down. R38's TIC assessment dated 2/12/25, identified R38 was involved in a situation in which they were seriously injured or had been in a situation in which they feare they might be seriously injured or killed. R38 reported the situation included being attacked. The assessment identified R38	{F 657}	Social Services Director will update the resident trauma care plan. Social Services Director and Case Managers will be educated by the DON and/or designee on the Person-Centered Care Planning Policy and Trauma Informed Care policy, including updating resident's care plans with results from the Trauma Informed Care Assessment. DON and/or designee will audit resident trauma care plans to ensure it is up to date and any new triggers and interventions identified in the Trauma Informed Care Assessment are included, 3x/week x2 weeks, 2x/week x2weeks, then weekly thereafter, beginning 05/05/2025. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 657}	Continued From page 3 reported they would like to see a mental health care provider. R38's undated care plan failed to identify concerns related to past trauma and interventions to help prevent re-trauma. On 4/24/25 at 1:10 p.m., the social services (SS)-A stated TIC assessments were completed with the resident and/or family upon admission and whenever there was a change in the residents condition. The residents care plan was updated according to their reported interventions. SS-A stated staff review the care plan for target behaviors and interventions specific to each resident. SS-A stated R7's care plan failed to identify specific person-centered interventions that helped R7 with her trauma. The facility policy Person Centered Care Planning revised 12/18/23, identified the facility would will develop a comprehensive person-centered care plan with the resident and/or family representative for each resident in the facility, consistent with the resident's rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. The resident's care plan was reviewed every 90 days or more frequently if necessary with a significant change. Care plans were updated on an ongoing basis as needed based on changes that occur between care conferences.	{F 657}		
{F 880} SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	{F 880}		5/12/25

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 4 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	{F 880}		

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 5 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow transmission-based precautions (TBP) for residents symptomatic for Norovirus according to Centers for Disease Control and Prevention (CDC) for 1 of 3 residents (R3) reviewed for infections; failed to follow COVID-19 testing guidance for 1 of 3 residents (R11) who displayed signs and symptoms of potential infection; and failed to implement timely droplet precautions for 1 of 3 residents (R1) who displayed signs and symptoms of potential infection. This had the potential to affect all 38 residents currently	{F 880}	R3 was removed from contact precautions on 04/25/2025, after being symptom free x72hours. RN-A will be educated on following transmission-based precautions by the DON and/or designee. R11 was retested for Covid-19 via rapid antigen test on 04/25/25 and results were negative. R1 was removed from droplet precautions on 04/23/2025 after 24 hours symptom free.	

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 6 residing in the facility. Findings include: The Centers for Disease Control and Prevention (CDC) Norovirus Outbreaks revised 2/2/25, identified Norovirus was a highly contagious virus that caused gastroenteritis, leading to symptoms such as nausea, vomiting, diarrhea, and stomach cramping. It spreads easily through contaminated food, water, surfaces, and from person to person. R3's quarterly Minimum Data Set (MDS) dated 4/8/25, identified R3 had severe cognitive impairment and diagnoses included chronic obstructive pulmonary disease and hemiplegia (one sided paralysis). R3 was always incontinent of bowel and bladder and required partial to moderate staff assistance for toileting and hygiene. R3's care plan revised 3/26/25, identified R3 was at risk of developing Norovirus related to an outbreak in the facility. Staff were directed to monitor for signs and symptoms of Norovirus (nausea, vomiting, diarrhea, body aches, fever and chills). Staff were to notify R3's physician if R3 exhibited signs and symptoms of Norovirus and implement Contact Isolation Precautions. R3's nursing progress note dated 4/18/25 at 9:06 a.m., identified R3 was reported to have diarrhea. R3 was placed on contact precautions and isolation precautions for 3-7 days, were orders placed for isolation documentation every shift, personnel protective equipment (PPE) and signage was placed outside R3's room. - On 4/21/24 at 4:28 p.m., R3 was on contact isolation precautions since 4/18/25 for loose	{F 880}	All residents have the potential to be affected by this deficient practice. DON reviewed the Transmission Based Precautions Policy on 5/2/25 with no changes needed. DON reviewed the COVID-19 Testing policy on 5/5/25 and updates were made to include confirming an antigen test result with another rapid antigen test or RT-PCR test and that the time interval between the two sample collections is 48 hours. All current residents will have a chart review completed by the DON and/or designee to ensure appropriate transmission-based precautions have been implemented per policy and that COVID-19 testing has been completed per policy. DON and/or designee will re-educate all staff on the Transmission Based Precautions policy, including implementing transmission-based precautions, following transmission-based precautions, appropriate use of PPE, donning/doffing of PPE, shift communication and hand off reporting related to signs and symptoms of potential/active resident infection, by holding mandatory in-person training sessions. DON and/or designee will educate all licensed nurses on the COVID-19 testing policy, including a negative rapid antigen test result may need to be confirmed using another rapid antigen test or a RT-PCR test, especially if the result of the antigen test is inconsistent with the clinical symptoms. When confirming an antigen test result with a rapid antigen or RT-PCR	

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 7 stool. R3's last loose stool was 4/19/25. R3 was in a single room with all meal and services brought to room. R3 would remain on isolation until symptom free for 72 hours. R3's medical record identified R3 had bowel movements on the following days: 4/18/25 loose/diarrhea stools 5 times. 4/19/25 loose/diarrhea stool once and puttylike consistency once. 4/20/25 putty-like consistency once. 4/21/25 loose/diarrhea once and formed once. 4/22/25 loose/diarrhea once. During an observation on 4/23/25 at 9:24 a.m., R3 was lying in bed on his right side with blankets covering to his chest. There was a contact precautions sign on R3's door with a 3-drawer plastic bin with PPE (gowns, gloves, and surgical masks) outside R3's room. - At 9:27 a.m., registered nurse (RN)-A entered R3's room with a surgical mask but did not put on a gown or gloves. RN-A listened to R3's apical pulse using a stethoscope. RN-A was near R3 with RN-A uniform brushing up against R3's bed linens and trash bin. RN-A touched R3's personnel items on R3's overbed table. RN-A then exited R3's room and used hand sanitizer. - At 9:30 a.m., RN-A dispensed R3's medications from the medication cart. RN-A's uniform brushed up against the medication cart. - At 9:34 a.m., RN-A entered R3's room. RN-A wore a surgical mask but did not put on a gown or gloves. RN-A administered R3's medications while handing R3 the thermal water mug from R3's overbed table and brushing up against R3's bed linens. RN-A used hand sanitizer before leaving R3's room.	{F 880}	test, the time interval between the two sample collections is 48 hours. DON and/or designee will perform competency testing for all staff on Donning and Doffing PPE. The DON and/or designee will perform audits 3x/week x2 weeks, 2x/week x2 weeks, then weekly thereafter beginning 05/05/2025 to ensure transmission-based precautions were appropriately implemented per policy. The DON and/or designee will perform audits 3x/week x2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning 05/05/2025 to ensure staff are wearing the appropriate PPE per the type of transmission-based precautions. The DON and/or designee will perform audits 3x/week x2 weeks, 2x/week x2 weeks, then weekly thereafter beginning 05/05/2025 that COVID-19 testing was completed per policy. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 8 During an interview on 4/23/25 at 9:40 a.m., RN-A stated she was the facility's infection prevention nurse but was working as the medication nurse because the facility was short-staffed. RN-A stated R3 was no longer on contact precautions, but then looked at the contact precautions sign on R3's door and stated "oh, wait." RN-A then stated the director of nursing (DON) had reviewed R3's chart and reported R3 continued to require contact precautions because R3 continued to have loose stools. RN-A stated she was thinking R3's contact precautions had been removed and just didn't see the sign. RN-A stated she should have worn a gown and gloves when entering R3's room. "I just forgot." R3 had to remain on contact precautions until R3 did not have loose stools for 72 hours. During an interview on 4/23/25 at 5:13 p.m., the DON stated the facility educated all staff on the different viruses, what type of precautions were required and what staff were expected to do when a resident was showing symptoms. Staff were provided education regarding donning (putting on) and doffing (removing) PPE. All staff were expected to follow precautions. The facility had been experiencing outbreak of different viruses for the previous two months and staff were just fatigued, however, if the sign was on a resident's door the precautions must be followed. The facility policy Transmission-Based Precautions revised 3/21/25, identified the following: Implement Contact Precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care	{F 880}		

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 9	{F 880}		

items in the resident's environment. Contact Precautions may be modified to allow MDRO colonized/infected residents whose site of colonization or infection can be appropriately contained and who can observe good hand hygiene practices, etc. to enter common areas and participate in group activities:
a. appropriate resident placement.
b. appropriate personal protective equipment. Donning and doffing of PPE will be done following CDC guidelines.
c. disposable or dedicated resident equipment.
d. limited transport or movement of resident outside of the room.

The CDC's Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions revised 2/7/25, identified to use contact precautions for a minimum of 48 hours after the resolution of symptoms or to control institutional outbreaks.

R11's quarterly MDS dated 2/18/25, identified R11 had a severe cognitive impairment and had diagnoses that included Alzheimer's disease and dementia.

R11's nursing progress note dated 4/21/25 at 11:41 a.m., identified staff reported R11 had a deep cough and was congested, per infection control recommendations R11 placed on droplet precautions and swabbed for a respiratory panel. DON and physician was advised. R11's temperature was 98.7 degrees Fahrenheit and lung sounds were clear. Family member (FM)-A updated and verbalized understanding.
- At 3:52 p.m., due to R11's insurance not covering the respiratory panel, and the out-of-pocket expense was $968.98, FM-A

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 10 decided to opt out of having the panel completed. - On 4/22/25 at 11:10 a.m., R11 was tested for COVID-19 and was negative. During an observation on 4/23/25 at 2:00 p.m., R11 was sitting at a dining room table eating a snack. The droplet precautions sign was, and PPE cart was removed from R11's room. During an interview on 4/23/25 at 4:13 p.m., RN-A stated the facility had an outbreak of respiratory illness. Some respiratory panels were completed and returned positive for Rhinovirus (a type of virus that primarily causes the common cold. Rhinovirus is highly contagious and spread through respiratory droplets when an infected person coughs or sneezes, or through direct contact with contaminated surfaces. Once the virus enters the body, it typically infects the upper respiratory tract, leading to symptoms like a runny nose, sore throat, cough, sneezing, and sometimes a mild fever). A respiratory panel was attempted for R11, but FM-A refused R11's respiratory panel due to the cost. R11's respiratory symptoms had resolved and R11 was removed from contact precautions. However, RN-A was unaware R11 was tested for COVID-19 using the facility's rapid POC antigen test but RN-A had forgotten a confirmatory test was required before a resident could be removed from droplet precautions if symptomatic. During an interview on 4/23/25 at 5:13 p.m., the DON stated staff were expected to follow CDC guidance regarding COVID-19 testing. R1's admission MDS dated 3/20/25, identified R1 had a severe cognitive impairment and had diagnoses that included Alzheimer's Disease,	{F 880}		

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 11 dementia, and type 2 diabetes. R1's nursing progress notes identified the following: - On 4/19/25 at 9:20 p.m., around 7:00, R1 had been sitting at a dining room table and suddenly slumped over and was unconscious. Staff that was nearby, attempted to sit R1 up and talk to her but R1 continued to be unresponsive. Staff obtained R1's vitals and everything was within normal limits, but R1's oxygen saturations had dropped and kept dropping below 85%. R1's skin color looked grey and R1 felt warm. Staff were able to get R1 in a chair and transport R1 to R1's room and get R1 into bed. Oxygen was put on and at first it was difficult to get R1's oxygen saturations to come up, so a full mask was put on and R1 eventually came up to 91-92%. Family was called. R1 did start to come around and when staff would say R1's name, R1 would open her eyes and nod her head. Family has stated that at this time they did not wish to have R1 sent to the emergency room. R1's spouse was going to stay here over night with her. However, the note failed to identify R1 was placed in transmission-based precautions due to exhibiting symptoms of potential respiratory illness. - At 11:35 p.m., R1 was on 2 liters (L) of oxygen via nasal cannula with oxygen saturations maintaining between 91-93%. R1 did not interact or respond to staff during cares. VS were rechecked and were within normal limits. R1's family stated firmly they did not want R1 transferred to the hospital because the hospital would not do anything different than what the facility was doing and did not want to put R1 through the transfer. The main goal was to keep R1comfortable. R1's physician was notified of the situation and agreed with the current plan of care.	{F 880}		

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 12 However, the note failed to identify R1 was placed in transmission-based precautions due to exhibiting symptoms of potential respiratory illness. - On 4/20/25 at 2:07 p.m., R1 was alert and responding to family this morning when they were here visiting. R1 sat up in her bed and ate breakfast with them but ate very little, maybe a few bites of toast and a bite of egg. When R1 attempted to drink, R1 would cough and R1 sounded congested. R1 was afebrile. Staff did try to take off the oxygen but R1's oxygen saturations dropped to 88%. Oxygen was put back on and she has been holding steady at 94%. However, the note failed to identify R1 was placed in transmission-based precautions due to exhibiting symptoms of potential respiratory illness. - On 4/21/25 at 7:52 a.m., R1 was tested for COVID-19 which had negative results. However, the note failed to identify R1 was placed in transmission-based precautions due to exhibiting symptoms of potential respiratory illness and/or the plan for a confirmatory COVID-19 test. - At 10:10 a.m., R1 seemed to be perking up today. More alert and did attempt to talk when asked a question. Morning medications given, crushed and in applesauce, R1 also ate a whole container of applesauce. Had difficulty sucking on a straw due to facial tremor, so staff were giving her water through a straw by dropping into R1's mouth and R1 seemed to do well with that. - At 11:59 a.m., R1 was placed on droplet precautions. Family was aware. R1 was swabbed for a respiratory panel. T-98.1 and lung sounds were clear. - At 2:02 p.m., R1 was placed on droplet precautions. Family was aware. R1 was swabbed for a respiratory panel. R1 has had a loose	{F 880}		

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 13	{F 880}		

cough. R1 was on oxygen and oxygen saturations were 91% on 2L.
- On 4/22/25 at 11:15 a.m., R1's respiratory panel results were negative. R1 would remain on droplet isolation transmission-based precautions until symptoms resolve.

During an interview on 4/22/25 at 4:45 p.m., licensed practical nurse (LPN)-A stated the communication between facility staff "was awful." During the weekend, no one reported to LPN-A there were residents with coughs and no residents were in transmission-based precautions. LPN-A was unsure when precautions were needed because it was confusing. Typically, the infection prevention nurse implemented precautions for residents Monday through Friday during her work hours. No other staff implemented them. Really, the only way LPN-A would know a resident was coughing or had loose stools would be a nursing assistant telling her. "Like I said, the communication is awful."

During an interview on 4/24/25 at 11:45 a.m., RN-B stated she worked the weekend of 4/19/25 and was unaware any resident was ill because no staff reported it to her. Any resident who exhibited symptoms of respiratory or gastrointestinal illness should have been put into isolation right away. Staff were trying to follow CDC guidance, but they did not always have the tools to do their jobs well. Staff were working short and were getting the minimum done.

During an interview on 4/23/25 at 4:13 p.m., RN-A stated the facility had an outbreak of respiratory illness. Some respiratory panels were completed and returned positive for Rhinovirus R1 should

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 14 have been put in precautions on 4/19/25 when R1 was exhibiting signs and symptoms of a possible respiratory infection. R1 had a urinary tract infection and RN-A did not consider a respiratory infection. Low oxygen saturations were a sign/symptom of COVID-19. The facility was working to get all staff to a system-wide effort to implement timely transmission-based precautions when RN-A was not at the facility. It was a work in progress. Staff just did not think of a cold, especially after the COVID-19 pandemic. All staff were just more relaxed but needed to remember even a cold was important. During an interview on 4/23/25 at 5:13 p.m., the DON stated staff were expected to follow CDC guidance regarding transmission-based precautions for residents showing signs/symptoms of respiratory illness and COVID-19 testing. The facility policy COVID-19 Testing revised 5/1/24, identified the facility would test residents and staff based on parameters defined by Center for Medicare and Medicaid Services (CMS), Minnesota Department of Health (MDH), and the Center for Disease Control and Prevention (CDC). If a resident has symptoms consistent with or has been exposed to COVID-19, or if there is a care center outbreak and the resident declines testing, he or she will be placed on or remain in quarantine until he or she meets the symptom-based criteria for discontinuation. Care center will document resident education, date of testing, and refusal. A. A negative rapid antigen test result may need to be confirmed using a RT-PCR test, especially if the result of the antigen test is inconsistent with the clinical symptoms. When confirming an	{F 880}		

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880}	Continued From page 15 antigen test result with a RT-PCR test, it is important that the time interval between the two sample collections is less than 48 hours, and there have not been any opportunities for new exposures between the two tests. If more than 48 hours separates the two tests, or there have been opportunities for new exposures between the two tests, the RT-PCR should be considered a separate test - not a confirmatory test. The CDC's Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions revised 2/7/25, identified to use droplet precautions and to add contact precautions if copious moist secretions and close contact likely to occur (e.g., young infants) for the duration of illness.	{F 880}		
{F 883} SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	{F 883}		5/12/25

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 883}	Continued From page 16 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the most recent Centers for Disease Control (CDC) education regarding	{F 883}	R1s representative was provided with Influenza VIS 01/31/2025, Covid VIS 01/31/2025 and Pneumococcal VIS	

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 883}	Continued From page 17 the potential risks and benefits of the pneumococcal, influenza and COVID-19 vaccines for 1 of 3 residents (R1) reviewed for immunizations Findings include: R1's admission MDS dated 3/20/25, identified R1 was admitted to the facility on 3/13/25, was 77 years old, had a severe cognitive impairment, and had diagnoses that included Alzheimer's Disease, dementia, and type 2 diabetes. R1's immunization record dated 4/24/25, identified R1 had received the following: - Novel Influenza-H1N1-09, all formulations on 11/25/09 - Pneumococcal PPSV23 on 11/14/12 - Prevnar 13 on 3/15/17 - COVID-19 on 1/29/21, 2/26/21 and 11/23/21 However, R1's medical record failed to identify R1 or R1's representative was provided the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal, influenza and COVID-19 vaccines. During an interview on 4/24/25 at 11:45 a.m., registered nurse (RN)-B stated she did not review immunizations when a resident was admitted to the facility because that was the role of the infection prevention nurse. During an interview on 4/23/25 at 4:13 p.m., RN-A stated she was responsible for the facility's infection prevention program. When a resident was admitted to the facility, within 7 days, either case managers or RN-A reviewed the resident's immunization record and complete the consent or	{F 883}	05/12/2023 on 04/24/2025 by the IPCO Nurse. All residents have the potential to be affected by this deficient practice. DON reviewed the Resident Immunizations policy on 5/5/25 with no changes needed. The Vaccination Consent form was updated on 5/5/25 to include the VIS Name and VIS Date for each type of vaccination. DON and/or designee will educate IPCO nurse and Case Manager's on the Resident Immunizations policy and identifying the VIS name and VIS date on the Vaccination Consent form that was provided to the resident and/or resident representative for each vaccination. DON and/or designee will review all current resident vaccinations that were provided, starting from September 2024 to current, to ensure that the most recent VIS was provided to the resident and/or resident representative based on the vaccination they received. If this was not completed, the DON and/or designee will provide the up-to-date VIS to the resident and/or resident representative and document the name and date of the VIS provided in the resident record. DON and/or designee will audit all new admissions to ensure they are up to date on recommended vaccinations and/or offered education on the risks and benefits of the immunizations along with the most recent VIS from the CDC, 2x/week x4 weeks, then weekly thereafter	

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 _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 883}	Continued From page 18 declination for COVID-19, influenza and pneumococcal vaccine. It could be an overwhelming task with all the admission duties. RN-A was aware there were residents who had recently been admitted who were not completed and should have been. During an interview on 4/23/25 at 5:13 p.m., the director of nursing (DON) stated staff were expected to review resident immunizations within 7 days of admission and provide education regarding the potential risks and benefits of the pneumococcal, influenza and COVID-19 vaccines. A facility immunization policy was requested but not received.	{F 883}	starting 05/05/2025. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically delivered

May 2, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

Re: CCN: 245542
Cycle Start Date: February 20, 2025

Dear Administrator:

On April 25, 2025, 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 February 27, 2025 with orders received by you electronically on March 4, 2025.

State licensing orders issued pursuant to the last survey completed on February 27, 2025, found not corrected at the time of this April 25, 2025 revisit and subject to penalty assessment are as follows:

20570	-- MN Rule 4658.0405 Subp. 4 -- Comprehensive Plan Of Care; Revision	$300.00
21375	-- MN Rule 4658.0800 Subp. 1 -- Infection Control; Program	$300.00
21426	-- MN St. Statute 144A.04 Subd. 3 -- Tuberculosis Prevention And Control	$0.00

The details of the violations noted at the time of this revisit completed on April 25, 2025 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, § 144A.10, you will be assessed an amount of $600.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office

Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to:

Shellae Dietrich, Health Program Manager
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/21/25 through 4/24/25, an on-site revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 2/27/25, by the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was	{2 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{2 000}	Continued From page 1 issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	{2 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{2 570}	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure care plan interventions were care planned according to assessments for 2 of 3 resident (R7, R38) reviewed for trauma informed care. Findings include: R7: R7's significant change Minimum Data Set (MDS) dated 3/5/25, identified R7 had post-traumatic stress disorder and sometimes displayed behaviors of social isolation. R7's Trauma-Informed Care (TIC) assessment dated 3/5/25, identified R7 was involved in a situation in which they were seriously injured or had been in a situation in which they feared they might be seriously injured or killed. R7 reported the situations included growing up in a violent	{2 570}	Corrected	5/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{2 570}	Continued From page 3 home, felt their life didn't have purpose, and was involved in an attempted sexual assault. The assessment identified R7 reported interventions that helped included yelling to defend self, talking to someone that listened (including counselor, family or friend), and coloring. R7's care plan revised 3/13/25, failed to identify the TIC interventions identified on the TIC assessment dated 3/5/25. R38: R38's admission MDS dated 2/21/25, identified R38 had diagnoses including insomnia and adult failure to thrive. The assessment identified during the 14 day look back period, R38 reported feeling the following: - 2-6 days had little interest or pleasure in doing things; had trouble concentrating on things, such as reading or watching tv. - 7-11 days had trouble falling or staying asleep, or sleeping too much; had thoughts that resident would be better off dead, or of hurting self in some way. - 12-14 days felt down, depressed, or hopeless; felt bad about self - or that resident was a failure or had let yourself or your family down. R38's TIC assessment dated 2/12/25, identified R38 was involved in a situation in which they were seriously injured or had been in a situation in which they feare they might be seriously injured or killed. R38 reported the situation included being attacked. The assessment identified R38 reported they would like to see a mental health care provider. R38's undated care plan failed to identify concerns related to past trauma and interventions	{2 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{2 570}	Continued From page 4 to help prevent re-trauma. On 4/24/25 at 1:10 p.m., the social services (SS)-A stated TIC assessments were completed with the resident and/or family upon admission and whenever there was a change in the residents condition. The residents care plan was updated according to their reported interventions. SS-A stated staff review the care plan for target behaviors and interventions specific to each resident. SS-A stated R7's care plan failed to identify specific person-centered interventions that helped R7 with her trauma. The facility policy Person Centered Care Planning revised 12/18/23, identified the facility would will develop a comprehensive person-centered care plan with the resident and/or family representative for each resident in the facility, consistent with the resident's rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. The resident's care plan was reviewed every 90 days or more frequently if necessary with a significant change. Care plans were updated on an ongoing basis as needed based on changes that occur between care conferences. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary and audit for ongoing compliance.	{2 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{2 570}	Continued From page 5 TIME PERIOD FOR CORRECTION: FOURTEEN (14) days.	{2 570}		
{21375}	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow transmission-based precautions (TBP) for residents symptomatic for Norovirus according to Centers for Disease Control and Prevention (CDC) for 1 of 3 residents (R3) reviewed for infections; failed to follow COVID-19 testing guidance for 1 of 3 residents (R11) who displayed signs and symptoms of potential infection; and failed to implement timely droplet precautions for 1 of 3 residents (R1) who displayed signs and symptoms of potential infection. This had the potential to affect all 38 residents currently residing in the facility. Findings include: The Centers for Disease Control and Prevention (CDC) Norovirus Outbreaks revised 2/2/25, identified Norovirus was a highly contagious virus that caused gastroenteritis, leading to symptoms such as nausea, vomiting, diarrhea, and stomach cramping. It spreads easily through contaminated food, water, surfaces, and from person to person.	{21375}	Corrected	5/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 6 R3's quarterly Minimum Data Set (MDS) dated 4/8/25, identified R3 had severe cognitive impairment and diagnoses included chronic obstructive pulmonary disease and hemiplegia (one sided paralysis). R3 was always incontinent of bowel and bladder and required partial to moderate staff assistance for toileting and hygiene. R3's care plan revised 3/26/25, identified R3 was at risk of developing Norovirus related to an outbreak in the facility. Staff were directed to monitor for signs and symptoms of Norovirus (nausea, vomiting, diarrhea, body aches, fever and chills). Staff were to notify R3's physician if R3 exhibited signs and symptoms of Norovirus and implement Contact Isolation Precautions. R3's nursing progress note dated 4/18/25 at 9:06 a.m., identified R3 was reported to have diarrhea. R3 was placed on contact precautions and isolation precautions for 3-7 days, were orders placed for isolation documentation every shift, personnel protective equipment (PPE) and signage was placed outside R3's room. - On 4/21/24 at 4:28 p.m., R3 was on contact isolation precautions since 4/18/25 for loose stool. R3's last loose stool was 4/19/25. R3 was in a single room with all meal and services brought to room. R3 would remain on isolation until symptom free for 72 hours. R3's medical record identified R3 had bowel movements on the following days: 4/18/25 loose/diarrhea stools 5 times. 4/19/25 loose/diarrhea stool once and puttylike consistency once. 4/20/25 putty-like consistency once. 4/21/25 loose/diarrhea once and formed once. 4/22/25 loose/diarrhea once.	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 7 During an observation on 4/23/25 at 9:24 a.m., R3 was lying in bed on his right side with blankets covering to his chest. There was a contact precautions sign on R3's door with a 3-drawer plastic bin with PPE (gowns, gloves, and surgical masks) outside R3's room. - At 9:27 a.m., registered nurse (RN)-A entered R3's room with a surgical mask but did not put on a gown or gloves. RN-A listened to R3's apical pulse using a stethoscope. RN-A was near R3 with RN-A uniform brushing up against R3's bed linens and trash bin. RN-A touched R3's personnel items on R3's overbed table. RN-A then exited R3's room and used hand sanitizer. - At 9:30 a.m., RN-A dispensed R3's medications from the medication cart. RN-A's uniform brushed up against the medication cart. - At 9:34 a.m., RN-A entered R3's room. RN-A wore a surgical mask but did not put on a gown or gloves. RN-A administered R3's medications while handing R3 the thermal water mug from R3's overbed table and brushing up against R3's bed linens. RN-A used hand sanitizer before leaving R3's room. During an interview on 4/23/25 at 9:40 a.m., RN-A stated she was the facility's infection prevention nurse but was working as the medication nurse because the facility was short-staffed. RN-A stated R3 was no longer on contact precautions, but then looked at the contact precautions sign on R3's door and stated "oh, wait." RN-A then stated the director of nursing (DON) had reviewed R3's chart and reported R3 continued to require contact precautions because R3 continued to have loose stools. RN-A stated she was thinking R3's contact precautions had been removed and just didn't see the sign. RN-A stated she should have worn a gown and gloves when entering R3's	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 8 room. "I just forgot." R3 had to remain on contact precautions until R3 did not have loose stools for 72 hours. During an interview on 4/23/25 at 5:13 p.m., the DON stated the facility educated all staff on the different viruses, what type of precautions were required and what staff were expected to do when a resident was showing symptoms. Staff were provided education regarding donning (putting on) and doffing (removing) PPE. All staff were expected to follow precautions. The facility had been experiencing outbreak of different viruses for the previous two months and staff were just fatigued, however, if the sign was on a resident's door the precautions must be followed. The facility policy Transmission-Based Precautions revised 3/21/25, identified the following: Implement Contact Precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Contact Precautions may be modified to allow MDRO colonized/infected residents whose site of colonization or infection can be appropriately contained and who can observe good hand hygiene practices, etc. to enter common areas and participate in group activities: a. appropriate resident placement. b. appropriate personal protective equipment. Donning and doffing of PPE will be done following CDC guidelines. c. disposable or dedicated resident equipment. d. limited transport or movement of resident outside of the room.	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 9 The CDC's Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions revised 2/7/25, identified to use contact precautions for a minimum of 48 hours after the resolution of symptoms or to control institutional outbreaks. R11's quarterly MDS dated 2/18/25, identified R11 had a severe cognitive impairment and had diagnoses that included Alzheimer's disease and dementia. R11's nursing progress note dated 4/21/25 at 11:41 a.m., identified staff reported R11 had a deep cough and was congested, per infection control recommendations R11 placed on droplet precautions and swabbed for a respiratory panel. DON and physician was advised. R11's temperature was 98.7 degrees Fahrenheit and lung sounds were clear. Family member (FM)-A updated and verbalized understanding. - At 3:52 p.m., due to R11's insurance not covering the respiratory panel, and the out-of-pocket expense was $968.98, FM-A decided to opt out of having the panel completed. - On 4/22/25 at 11:10 a.m., R11 was tested for COVID-19 and was negative. During an observation on 4/23/25 at 2:00 p.m., R11 was sitting at a dining room table eating a snack. The droplet precautions sign was, and PPE cart was removed from R11's room. During an interview on 4/23/25 at 4:13 p.m., RN-A stated the facility had an outbreak of respiratory illness. Some respiratory panels were completed and returned positive for Rhinovirus (a type of virus that primarily causes the common cold. Rhinovirus is highly contagious and spread through respiratory droplets when an infected	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 10 person coughs or sneezes, or through direct contact with contaminated surfaces. Once the virus enters the body, it typically infects the upper respiratory tract, leading to symptoms like a runny nose, sore throat, cough, sneezing, and sometimes a mild fever). A respiratory panel was attempted for R11, but FM-A refused R11's respiratory panel due to the cost. R11's respiratory symptoms had resolved and R11 was removed from contact precautions. However, RN-A was unaware R11 was tested for COVID-19 using the facility's rapid POC antigen test but RN-A had forgotten a confirmatory test was required before a resident could be removed from droplet precautions if symptomatic. During an interview on 4/23/25 at 5:13 p.m., the DON stated staff were expected to follow CDC guidance regarding COVID-19 testing. R1's admission MDS dated 3/20/25, identified R1 had a severe cognitive impairment and had diagnoses that included Alzheimer's Disease, dementia, and type 2 diabetes. R1's nursing progress notes identified the following: - On 4/19/25 at 9:20 p.m., around 7:00, R1 had been sitting at a dining room table and suddenly slumped over and was unconscious. Staff that was nearby, attempted to sit R1 up and talk to her but R1 continued to be unresponsive. Staff obtained R1's vitals and everything was within normal limits, but R1's oxygen saturations had dropped and kept dropping below 85%. R1's skin color looked grey and R1 felt warm. Staff were able to get R1 in a chair and transport R1 to R1's room and get R1 into bed. Oxygen was put on and at first it was difficult to get R1's oxygen saturations to come up, so a full mask was put on	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 11 and R1 eventually came up to 91-92%. Family was called. R1 did start to come around and when staff would say R1's name, R1 would open her eyes and nod her head. Family has stated that at this time they did not wish to have R1 sent to the emergency room. R1's spouse was going to stay here over night with her. However, the note failed to identify R1 was placed in transmission-based precautions due to exhibiting symptoms of potential respiratory illness. - At 11:35 p.m., R1 was on 2 liters (L) of oxygen via nasal cannula with oxygen saturations maintaining between 91-93%. R1 did not interact or respond to staff during cares. VS were rechecked and were within normal limits. R1's family stated firmly they did not want R1 transferred to the hospital because the hospital would not do anything different than what the facility was doing and did not want to put R1 through the transfer. The main goal was to keep R1comfortable. R1's physician was notified of the situation and agreed with the current plan of care. However, the note failed to identify R1 was placed in transmission-based precautions due to exhibiting symptoms of potential respiratory illness. - On 4/20/25 at 2:07 p.m., R1 was alert and responding to family this morning when they were here visiting. R1 sat up in her bed and ate breakfast with them but ate very little, maybe a few bites of toast and a bite of egg. When R1 attempted to drink, R1 would cough and R1 sounded congested. R1 was afebrile. Staff did try to take off the oxygen but R1's oxygen saturations dropped to 88%. Oxygen was put back on and she has been holding steady at 94%. However, the note failed to identify R1 was placed in transmission-based precautions due to exhibiting symptoms of potential respiratory illness.	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 12 - On 4/21/25 at 7:52 a.m., R1 was tested for COVID-19 which had negative results. However, the note failed to identify R1 was placed in transmission-based precautions due to exhibiting symptoms of potential respiratory illness and/or the plan for a confirmatory COVID-19 test. - At 10:10 a.m., R1 seemed to be perking up today. More alert and did attempt to talk when asked a question. Morning medications given, crushed and in applesauce, R1 also ate a whole container of applesauce. Had difficulty sucking on a straw due to facial tremor, so staff were giving her water through a straw by dropping into R1's mouth and R1 seemed to do well with that. - At 11:59 a.m., R1 was placed on droplet precautions. Family was aware. R1 was swabbed for a respiratory panel. T-98.1 and lung sounds were clear. - At 2:02 p.m., R1 was placed on droplet precautions. Family was aware. R1 was swabbed for a respiratory panel. R1 has had a loose cough. R1 was on oxygen and oxygen saturations were 91% on 2L. - On 4/22/25 at 11:15 a.m., R1's respiratory panel results were negative. R1 would remain on droplet isolation transmission-based precautions until symptoms resolve. During an interview on 4/22/25 at 4:45 p.m., licensed practical nurse (LPN)-A stated the communication between facility staff "was awful." During the weekend, no one reported to LPN-A there were residents with coughs and no residents were in transmission-based precautions. LPN-A was unsure when precautions were needed because it was confusing. Typically, the infection prevention nurse implemented precautions for residents Monday through Friday during her work hours. No other staff implemented them. Really, the only	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 13 way LPN-A would know a resident was coughing or had loose stools would be a nursing assistant telling her. "Like I said, the communication is awful." During an interview on 4/24/25 at 11:45 a.m., RN-B stated she worked the weekend of 4/19/25 and was unaware any resident was ill because no staff reported it to her. Any resident who exhibited symptoms of respiratory or gastrointestinal illness should have been put into isolation right away. Staff were trying to follow CDC guidance, but they did not always have the tools to do their jobs well. Staff were working short and were getting the minimum done. During an interview on 4/23/25 at 4:13 p.m., RN-A stated the facility had an outbreak of respiratory illness. Some respiratory panels were completed and returned positive for Rhinovirus R1 should have been put in precautions on 4/19/25 when R1 was exhibiting signs and symptoms of a possible respiratory infection. R1 had a urinary tract infection and RN-A did not consider a respiratory infection. Low oxygen saturations were a sign/symptom of COVID-19. The facility was working to get all staff to a system-wide effort to implement timely transmission-based precautions when RN-A was not at the facility. It was a work in progress. Staff just did not think of a cold, especially after the COVID-19 pandemic. All staff were just more relaxed but needed to remember even a cold was important. During an interview on 4/23/25 at 5:13 p.m., the DON stated staff were expected to follow CDC guidance regarding transmission-based precautions for residents showing signs/symptoms of respiratory illness and COVID-19 testing.	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 14 The facility policy COVID-19 Testing revised 5/1/24, identified the facility would test residents and staff based on parameters defined by Center for Medicare and Medicaid Services (CMS), Minnesota Department of Health (MDH), and the Center for Disease Control and Prevention (CDC). If a resident has symptoms consistent with or has been exposed to COVID-19, or if there is a care center outbreak and the resident declines testing, he or she will be placed on or remain in quarantine until he or she meets the symptom-based criteria for discontinuation. Care center will document resident education, date of testing, and refusal. A. A negative rapid antigen test result may need to be confirmed using a RT-PCR test, especially if the result of the antigen test is inconsistent with the clinical symptoms. When confirming an antigen test result with a RT-PCR test, it is important that the time interval between the two sample collections is less than 48 hours, and there have not been any opportunities for new exposures between the two tests. If more than 48 hours separates the two tests, or there have been opportunities for new exposures between the two tests, the RT-PCR should be considered a separate test - not a confirmatory test. The CDC's Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions revised 2/7/25, identified to use droplet precautions and to add contact precautions if copious moist secretions and close contact likely to occur (e.g., young infants) for the duration of illness. SUGGESTED METHOD OF CORRECTION: The DON or designee should review facility policies regarding implementation of transmission-based	{21375}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21375}	Continued From page 15 precautions and respiratory testing to identfy issues with implementation and revise as needed. The DON or designee could provide direct education and competency testing via return demonstration and or test to ensure all staff understand the requirements. Then the DON or designee coupld perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: FOURTEEN (14) DAYS.	{21375}		
{21426}	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	{21426}		5/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21426}	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a screening for tuberculosis (TB) symptoms was completed upon admission for 1 of 1 residents (R31) reviewed for tuberculosis practices. Findings include: R31's quarterly minimum data set (MDS) dated 2/25/25, identified R31 was admitted on 8/22/24. R31's diagnoses included renal failure and diabetes. R31's medical record lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. On 4/24/25 at 11:45 a.m., registered nurse (RN)-B stated the infection control nurse was responsible for completing resident TB screening and the floor nurses were responsible to administer the vaccine. RN-B stated she thought the screening was not needed because the facility used a blood test rather than the 2 step mantoux. On 4/23/25 at 4:13 p.m., RN-A stated she was responsible for completing the TB screening with the resident/resident representative. RN-A stated she was aware there were residents who did not have a screening completed but had not addressed them. On 4/23/25 at 5:13 p.m., the director of nursing (DON) stated she was aware there were	{21426}	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	R-C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
{21426}	Continued From page 17 residents who did not have a TB screening completed. Staff were expected to do TB screening and ensure the testing was completed. The Resident Tuberculosis Prevention and Control policy revised 1/21/25, identified each resident admitted to the care center would be required to have a written assessment of the resident's risk factors for TB along with any current TB symptoms. An Interferon-Gamma Release Assay Test (T-Spot or TB Gold) or a standard two-step TST would be initiated within 72 hours after admission to the care center and would be documented in the resident electronic medical record. SUGGESTED METHOD OF CORRECTION: The DON or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: FOURTEEN- (14) days.	{21426}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 12, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: February 20, 2025

Dear Administrator:

On February 27, 2025, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 26, 2025, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 27, 2025.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 27, 2025,(42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 27, 2025,(42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 27, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Littlefork Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 27, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 20, 2025 (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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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
E 000	Initial Comments On 2/24/25 through 2/27/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/24/25 through 2/27/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55428303C (MN00110637) and H55428385C (MN00110824) The survey resulted in an Immediate Jeopardy (IJ), at F880, F600 when a resident exhibited symptoms of respiratory illness, was not isolated or placed on transmission-based precautions when symptoms were exhibited, and subsequently tested positive for influenza A on 2/14/25, and failed to implement interventions to reduce the spread of influenza A which resulted in eight other residents contracting influenza A. The director of nursing (DON) was notified of the IJ on 2/24/25, at 9:27 p.m. The IJ was removed on 2/26/24, at 10:26 a.m. when the facility	F 000		

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

Electronically Signed | 03/20/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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	Continued From page 1 implemented actions to reduce/prevent the spread of illness. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 577		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 577	Continued From page 2 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the state agency (SA) survey results were available for residents voiced by 2 of 3 residents (R4, R25) who attended resident council meetings. In addition, the facility failed to ensure the most recent SA survey results were readily accessible at all times. This had the potential to affect all 38 residents and families that may wish to review the results. Findings include: R4's quarterly Minumum Data Set (MDS) dated 1/3/25, indentified R4 was cognitively intact. R25's annual MDS dated 1/2/25, indentified R25 was cognitively intact. During the resdient council meeting on 2/25/25 at 2:27 p.m., R4 and R25 were in attendance. Both residents stated they regularly attended resident council meetings. R4 and R25 were aware the SA survey results were to be available, although did not know where the results were located. During observation on 2/25/25 at 2:04 p.m., there was a binder hanging on the wall across from the nurses station near the main entrance to the facility. The binder was labeled "Minnesota Department of Health Survey Results" on the front and "MDH Survey Results" on the spine of the binder. Review of the survey binder identified	F 577	1. DON or designee will print all State Surveys that are missing along with any POCs and update the survey binder going back 3 years. 2. DON or designee will notify R4 and R25 where the survey results book is located. 3. All residents have the potential to be affected by this deficient practice. 4. Residents will be informed at each resident council meeting of the location of the survey binder by the Activity Director going forward. 5. DON or designee will post a notice of availability of survey reports in a prominent area that is accessible to the public. Post will include that the past 3 years of survey results are available with direction on who to ask with any questions. 6. DON or designee will update the survey binder with any new SA survey results ongoing ensuring the past 3 years are available. 7. DON or designee will audit survey binder every other week x 2 months, then monthly thereafter beginning the week of 3/24/25 to ensure all surveys from the past three years are present. 8. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 577	Continued From page 3 the most recent posted survey result was dated 12/5/22. There was no notice identfiying the last three years survey results were available upon request and who to request them from. The binder lacked the following surveys: - 2/6/23, stand-alone abbreviated survey - 7/25/24, stand-alone abbreviated survey - 9/5/24, stand-alone abbreviated survey - 9/26/24, stand-alone abbreviated survey - 1/23/25, stand-alone abbreviated survey - 2/19/25, stand-alone abbreviated survey - 2/26/25, recertification survey On 2/27/25 at 4:14 p.m., the director of nursing (DON) stated the survey binder should have the past three years of survey results available for residents, family and visitors to review. The DON stated the last posted survey in the binder was dated 12/5/22. A policy for survey binder posting was requested but not received.	F 577	ongoing monitoring.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 580	Continued From page 4 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to timely notify the physician when a	F 580	Wound nurse and or/ licensed nurse to notify R18s primary physician with any	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 580	Continued From page 5 hematoma (localized collection of blood outside of blood vessels) was identified and subsequently opened requiring a new intervention for 1 of 2 (R18) residents reviewed for wound care. Findings include: R18's significant change Minimum Data Set (MDS) dated 1/6/25, identified R18 had severe cognitive impairment and did not exhibit behaviors during the assessment period. Diagnoses included Alzheimer's disease and a methicillin-resistant staphylococcus aureus (MRSA) infection. R18 had an open lesion other than ulcers, rashes or cuts. No pressure, venous or arterial ulcers. R18's undated care plan, identified R18 had impaired skin integrity due to a tissue injury. Staff were directed to encourage R18 to elevate legs, R18 had an air mattress on my bed, measure ulcer on at regular intervals, monitor ulcer for signs of infection, monitor ulcer for signs of progression or declination, notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. R18's nursing progress note dated 11/22/24 at 1:15 a.m., identified a loud scream was heard and then a crash. R18 was found almost up against the door. Staff had to push the door open until staff could fit through. Stepped over R18 walker R18 was sitting up against her closet. R18 was confused. R18 said she was just getting up. R18 did say she hurt everywhere A quick exam was done. R18 asked to be put back to bed. When R18 was put in bed, nursing assistant noted a big black bruised lump on her right inner shin. R18 continues to say she hurt everywhere.	F 580	significant change to wound to right upper shin. All residents with skin alterations have the potential to be affected by this deficient practice. Wound Nurse and/or designee will audit all residents with skin alterations, to ensure proper notification of MD was completed upon initial identification and/or with any significant changes to the skin alteration. If MD was not notified with any new skin alteration and/or significant change in a skin alteration status, the MD will be notified by the Wound Nurse and/or designee. Notification of Significant Changes policy was reviewed by the DON on 03/17/25 with no changes needed. All licensed nurses will be educated by the DON and/or designee on the Notification of Significant Changes policy, including notifying residents primary provider with any significant change with skin alterations and documenting this notification in the wound assessment or progress notes. DON and/or designee will audit that the residents primary care provider was notified of any resident significant change in condition 3x/week x2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning the week of 03/24/25. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 580	Continued From page 6 Vitals were obtained while phones calls were made to R18's son. At 1:30 am., R18's son said to send her to the emergency room. On-call RN was notified. R18's medical record failed to identify R18's hematoma until 12/12/24. R18's Skin/Wound note dated 12/12/24 at 2:19 p.m., identified the medical director (MD) was in the facility doing monthly wound rounds. R18 was sitting in the hallway in her wheelchair and nursing asked MD to take a look at R18's leg and assess. The MD examined the right calf and stated that area appeared to be a hematoma in which the skin was fully intact. R18 asked the provider if there was anything MD could give R18 to take care of it and MD told R18 that it just takes time to heal. MD stated to the current plan of care was adequate and that no further treatment was needed at this time. R18's N Adv - Skin Check dated 12/12/24 at 2:43 p.m., identified bruising purple and red inner lower right leg approximately 18 centimeter (cm) x 10cm, warm with dark purple raised area in middle of 2 cm x 2 cm, skin intact. R18's Skin/Wound note dated 12/19/24 at 7:30 a.m., identified the hematoma on R18's right leg broke open during the night and bled all over her bed. Old dressing was taken off and the swelling had gone down, and copious amounts old blood was draining from the wound. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/19/24 at 5:03 p.m., identified wound dressing to R18's lower	F 580	ongoing monitoring	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 580	Continued From page 7	F 580		

right extremity was changed again this afternoon due to bleeding through the dressing. Copious amounts of old blood were coming out of the hematoma wound itself. The note failed to identify if R18's physician was notified of R18's change in condition.

R18's Skin/Wound note dated 12/21/24 at 1:02 a.m., identified changed wound dressing to R18's right lower extremity due to bleeding through the dressing. The wound to mid-calf had copious amounts of serosanguineous drainage saturating the dressing. R18 tolerated dressing change without concern or complaint. The note failed to identify if R18's physician was notified of R18's change in condition.

R18's Skin/Wound note dated 12/21/24 at 10:27 a.m., identified R18 got a shower that morning. Dressing to
R18's wounds on her right leg were changed and redressed. Hematoma did not have any drainage on old dressing but skin tear near the ankle had a small amount of greenish drainage noted on old dressing. The note failed to identify if R18's physician was notified of R18's change in condition.

R18's nursing progress note dated 12/26/24 at 12:18 p.m., identified R18 had been out for both meals that morning. R18 denied any pain, unless she bumped her right leg on something. No new injuries or new bruises have been noted. Dressing to her right lower extremity continued to drain and did have an odor to it. The note failed to identify if R18's physician was notified of R18's change in condition.

R18's Transfer Out of Building note dated

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 580	Continued From page 8 12/23/24 at 2:52 p.m., identified dressing change was being done on right skin, wound appears to be worsening, a photo was sent to the medical director (MD) and per MD, R18 sent to the ER. During an interview on 2/27/25 at 1:40 p.m., RN-A stated she responsible for the facility's wound care. RN-A was not aware of R18's tissue injury until 12/12/24. The MD was in the building and RN-A asked for the MD to evaluated R18. Point of care (POC) treatment (measuring and monitoring) was ordered. Then, on 12/19/24, the deep tissue injury opened. RN-A was not working that day and RN-A was not informed until 12/23/24. RN-A contacted the MD and received an order to send R18 to the emergency room for evaluation. RN-A stated the on-call RN should have contacted the physician on 12/19/24 to update on R18's condition and request dressing orders. During a phone interview on 2/27/25 at 2:43 p.m., the MD stated he was not R18's primary physician but was the medical director for the facility. The MD did evaluate R18 on 12/12/24 and R18 had a large hematoma to the upper right shin. The area was not warm to the touch or open. The MD recommended monitoring the area for changes. MD was notified on 12/19/24, R18's hematoma had opened and the MD recommended transfer to the emergency room for evaluation. Normally, the MD would expect staff to contact the primary physician unless the physician was unavailable and to do so on 12/19/24 when R18's condition had changed. During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated any bruise/deep tissue injury should be followed and documented	F 580		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 580	Continued From page 9 daily and/or when there were changes. The physician should have been notified on 12/19/24 when R18's condition had changed. The facility policy Notification of Significant Changes revised 5/22/22, identified the facility would immediately inform the resident, consult with the physician, and notify the resident representative (consistent with his or her authority), when the resident had a significant change. The primary physician will be updated during regular business hours. If the primary physician is not available, the on-call physician will be updated, and the primary provider will be sent notification.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 657	Continued From page 10 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was updated timely to to prevent falls for 1 of 1 residents (R19) reviewed for falls. Findings include: R18's significant change Minimum Data Set (MDS) dated 1/6/25, identified R18 had a severe cognitive impairment and diagnoses that included Alzheimer's disease, dementia and osteoporosis. R18 had a fall without injury and a fall with injury. R18 did not use an alarm or any physical or electronic device that monitored R18's movement and alerted staff when movement was detected. R18's care plan revised 2/6/25, identified R18 was at risk for all related to confusion. Interventions included: - Assist R18 as needed with mobility and transfers - Be sure R18's call light was within reach and encourage R18 to use it for assistance as needed. - Bed in lowest position - Ensure that R18 was wearing appropriate footwear shoes when up ambulating or mobilizing in wheelchair and gripper socks when in bed. - R18 did not remember that R18 needed assistance with transfer or ambulation, anticipate	F 657	1. R19 safety plan related to falls will be reviewed and updated to reflect all current fall interventions by the Fall Coordinator. 2. All residents at risk for falls have the potential to be affected by this deficient practice. 3. DON reviewed the Person-Centered Care Planning policy on 03/17/25 with no changes needed. 4. Fall Coordinator and/or designee will review all residents' safety care plans who are at risk for falls to ensure they are up to date. 5. All registered nurses will be educated by the DON and/or designee on the Person-Centered Care Planning Policy, including updating residents care plans timely with any changes. 6. DON and/or designee will audit resident safety care plans to ensure it is up to date and any new intervention that was implemented was updated on the care plan on the same shift, 3x/week x2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning the week of 03/24/25. 7. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 657	Continued From page 11 needs. - R18 had a Bed sensor on R18's wall. - R18 had an easy touch call light under sheet, under R18's hip on R18's bed. - R18 needed a safe environment with floors free from spills and/or clutter; personal items within reach, gripper strips on floor in front of bed, recliner, and toilet - Keep R18 wheelchair next to R18 during meals and activities - R18 fall risk would be assessed every quarter and with change in condition R18's Incident Forms identified the following: - 11/7/24 at 8:45 a.m., identified R18 was heard yelling out for help, she was found lying on the floor in the hallway off the dining room. R18 was laying on the floor, laying on her right side. R18 stated she was walking to eat, and her knees just gave out and she fell to her knees and then fell to her right side. R18 would have been in bed three hours prior to fall. At 7:30 a.m., staff walked resident out to the dining room for breakfast. R18 was evaluated in the emergency room. Fall interventions included: physician reviewed medications, continue with present care plan, staff to offer to assist back to room when done with meals. However, the care plan was not revised to reflect this updated intervention. - 11/15/24 at 3:00 p.m., R18 was found lying on the floor. Fall interventions included toilet every two hours and follow care plan. However, the care plan was not revised to reflect this. - 11/22/24 at 1:15 a.m., identified R18 was found lying on the floor. Fall intervention included a flat sensor placed under sheet under hip. However,	F 657		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 657	Continued From page 12 the care plan was not revised to reflect this until 12/3/24. - 11/22/24 at 11:40 p.m., identified R18 was found lying on her left side next to her bed. Fall interventions included to place flat sensor under sheet under hip on bed. Referred to maintenance t to order. However, the care plan was not revised to reflect this until 12/3/24. During an interivew on 2/27/25 at 1:09 p.m., RN-E stated R18 was at risk for falls and R18's care plan was not revised to reflect toileting every two hours and/or for staff to assist R18 back to her room after meals. During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated staff were expected to revise resident care plans with identified fall interventions and were expected to follow the care plans to attempt to prevent further falls. The facility policy Person Centered Care Planning revised 12/18/23, identified the facility would will develop a comprehensive person-centered care plan with the resident and/or family representative for each resident in the facility, consistent with the resident's rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. The resident's care plan was reviewed every 90 days or more frequently if necessary with a significant change. Care plans were updated on an ongoing basis as needed based on changes that occur between care conferences.	F 657		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 676	Continued From page 13	F 676		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language,	F 676		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 676	Continued From page 14 (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure assistance was offered with meal setup to promote safety and independence with eating for 1 of 1 resident (R38) reviewed for activities of daily living (ADL) and needed set up and supervision to eat. Findings include: R38's admission Minimum Data Set (MDS) dated 2/12/25, identified R38 had intact cognition and required supervision or touching assistance with eating, maximum assistance with dressing and grooming and was dependent on staff for toileting, and transfers. Diagnoses included hemiplegia following cardiovascular disease and venous insufficiency. R38's Occupational Therapy (OT) Evaluation dated 2/7/25, identified R38 required supervision with eating and assistance to cut up his food. R38's Speech-Language Pathology Evaluation dated 2/11/25 identified R38 was edentulous (without teeth) and had top and bottom dentures but chose not to wear them. R38 was admitted on a soft and bite sized diet. R38 reported he was not having difficulty with regular textured food and would like to be upgraded. R38's progress note(s) identified the following: - 2/6/25, identified R38 was eating lunch in his room when his friend came to visit. The friend was upset that the lunch tray had been left for R38 in his room but had not been prepared so he could eat it. It was determined R38 should eat in	F 676	1. R38 Diet order will be reviewed DON and/or designee by 03/24/25. Any changes made will be updated in the resident's electronic health record and meal ticket. Dietary staff and nursing staff will be educated on any changes made by the RN Case Manager and/or designee. 2. RN Case Manager will assess R38 eating assistance needs and care plan will be updated with any changes. Nursing staff will be educated on R38s care plan related to eating assistance by the RN Case Manager and/or designee. 3. All residents who need assistance with eating have the potential to be affected by this deficient practice. 4. DON and/or designee will audit all residents who need assistance with eating to ensure their care plan reflects accurate assistance needed. Nursing staff will be educated on any changes made by the DON and/or designee. 5. Dietary Manager and/or designee will audit all residents meal tickets to ensure they accurately reflect the residents diet orders, and will update the meal tickets as needed. 6. The Activities of Daily Living policy was reviewed by the DON on 03/17/25 with no changes needed. 7. All nursing staff will be educated by the DON and/or designee on the Activities of Daily Living policy, including providing eating assistance to residents as necessary and per plan of care. 8. DON and/or designee will audit that	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 676	Continued From page 15 dining area for his meals to ensure he received the assistance when needed. - 2/12/25, R38 required supervision with eating and setup of his meal trays. R38 was a choking risk and was required to be in the dining room for meals to be observed. R38 was unable to cut up his foods and required food to be cut up small to prevent choking. R38's care plan dated 2/12/25, identified R38 had a swallowing problem related to coughing or choking during meals or swallowing medications. Interventions included for all staff to be informed of resident's special dietary and safety needs, eat only with supervision and to instruct R38 to eat in upright position, eat slowly and chew each bite thoroughly. R38 had hemiparesis on his left side and staff were to discuss concerns or issues regarding diagnosis. R38's care plan failed to identify R38's preference to have his food cut into small bites and/or his inability to cut up the food into small bites himself due to limited range of motion as assessed by OT. On 2/25/25, at 12:05 p.m. R38 was observed sitting at the dining room at a table in the back, away from most of the other residents and staff. R38 was served a sloppy Joe bun cut into quarters, whole french fries, a lettuce salad and two cups of liquid in covered cups with straws. R38 made no attempt to eat and remained seated in his wheelchair with his hands in his lap. At 12:25 p.m. R38 stated he was hungry but he did not think he could eat the food in front of him. He needed it cut up or something different. Three staff members were in the dining room assisting other residents, however, no one approached R38 to offer assistance. At 12:44 p.m. R38 remained seated in his wheelchair with his hands	F 676	residents are assisted with meal tray set-up and assistance with eating per plan of care 3x/week x 2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning 03/24/25. 9. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 676	Continued From page 16 in his lap and food untouched. No staff approached him to offer assistance. At 4:47 p.m. the director of nursing (DON) approached R38 and asked if she could assist him. R38 stated he was hungry but could not eat the meal and needed to have help to cut it up. The DON noticed R38 was overly warm and obtained another staff member to assist him to his room, bringing his lunch tray with him. During joint interview on 2/27/25, at 9:10 a.m. with nursing assistant (NA)-A and NA-H, NA-A stated R38 did not need help to eat but needed to eat in the dining room for supervision. NA-H stated R38 needed to have his food cut up in very small bites in order for him to eat. When interviewed on 2/27/25, at 9:44 a.m. registered nurse (RN)-B stated it was an issue if R38 had not gotten assistance to cut his food in small pieces. Cutting his sloppy Joe bun into quarters and serving whole baked french fries was not small bite size pieces and she was not sure if he should have even been served french fries as they would be difficult for him to eat. When staff put the plate of food in front of him they should immediately cut up the food into small bite size pieces. RN-B always asked R38 what she could do for him when she delivered his food. RN-B stated residents should be checked on in the dining room and 45 minutes was to long not to have someone to have had checked with him and offer assistance. During interview on 2/27/25, at 1:45 p.m. dietary aide (DA)-A stated if a resident had an order to have food cut up small and bite sized, the dietary staff would do that before serving the resident the meal. A sandwich cut into quarters and whole	F 676		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 676	Continued From page 17 crispy french fries would not be considered small and bite sized. DA-A did not think R38 had an order for small bite sized food anymore. R38 had graduated to a regular diet level and just could not have any food on the bone and his bacon needed to be soft. The dietary order indicated he was to take small bites and sips and alternate between bites and sips but not for dietary to cut up the food in small bites. R38's medical record lacked documentation R38's dietary needs, assistance with eating and food preferences had been reassessed, after being upgraded to a regular diet. During interview on 2/27/25, at 2:12 p.m. the director of nursing (DON) stated staff should have checked with R38 in the dining room when he had not attempted to eat. There wasn't a physician order to cut up R38's food in small bite size pieces but she would have expected the intervention to be on his care plan or at least to offer assistance with every meal. The facility's undated policy Activities of Daily Living, identified the purpose was to provide assistance to residents as necessary, to supervise and assess resident function in order to plan care to maintain optimum ADL function and to improve quality of life.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 18 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform ongoing monitoring and wound care for an injury for 1 of 2 residents (R18) reviewed for wound care; and the facility failed to implement interventions for edema for 1 of 1 resident (R38) reviewed for edema. Findings include: R18: R18's significant change Minimum Data Set (MDS) dated 1/6/25, identified R18 had severe cognitive impairment and did not exhibit behaviors during the assessment period. Diagnoses included Alzheimer's disease and a methicillin-resistant staphylococcus aureus (MRSA) infection. R18 had an open lesion other than ulcers, rashes or cuts. No pressure, venous or arterial ulcers. R18's undated care plan, identified R18 had impaired skin integrity due to a tissue injury. Staff were directed to encourage R18 to elevate legs, R18 had an air mattress on my bed, measure ulcer on at regular intervals, monitor ulcer for signs of infection, monitor ulcer for signs of progression or declination, notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. R18's nursing progress note dated 11/22/24 at	F 684	1. R18 right shin wound will be monitored and documented on weekly by the Wound nurse. Wound nurse will notify the primary provider with any significant changes in the wound. 2. Licensed Nurse to observe changes in R18 skin integrity and treatment and to notify RN Case Manager, Wound Nurse and/or designee with any changes per Skin Integrity policy. 3. All residents with wounds have the potential to be affected by this deficient practice. 4. The Skin Integrity policy was reviewed by the DON on 03/17/25 with no changes needed, 5. The DON and/or designee will review all residents with current wounds to ensure the primary provider has been notified of the wound, the primary provider was notified of any current significant change in the wound, there is a treatment plan in place for the wound, and weekly monitoring with documentation of the wound by the Wound Nurse. 6. All licensed nurses will be educated on the Skin Integrity policy by the DON and/or designee, including process for	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 19 1:15 a.m., identified a loud scream was heard and then a crash. R18 was found almost up against the door. Staff had to push the door open until staff could fit through. Stepped over R18 walker. R18 was sitting up against her closet. R18 was confused. R18 said she was just getting up. R18 did say she hurt everywhere A quick exam was done. R18 asked to be put back to bed. When R18 was put in bed, nursing assistant noted a big black bruised lump on her right inner shin. R18 continues to say she hurt everywhere. Vitals were obtained while phones calls were made to R18's son. At 1:30 am., R18's son said to send her to the emergency room. On-call RN was notified. R18's N Adv - Skin Check dated 12/2/24 at 10:13 a.m., identified a skin tear on R18's right lower leg. However, the note failed to identify R18's hematoma (an abnormal pooling of blood in the body under the skin that results from a broken or ruptured blood vessel) on the upper right shin. R18's medical record failed to identify R18's hematoma until 12/12/24. R18's Skin/Wound note dated 12/12/24 at 2:19 p.m., identified the medical director (MD) was in the facility doing monthly wound rounds. R18 was sitting in the hallway in her wheelchair and nursing asked MD to take a look at R18's leg and assess. The MD examined the right calf and stated that area appeared to be a hematoma in which the skin was fully intact. R18 asked the provider if there was anything MD could give R18 to take care of it and MD told R18 that it just takes time to heal. MD stated to the current plan of care was adequate and that no further treatment was needed at this time.	F 684	when a new skin issue is identified and process for ongoing monitoring of wounds. 7. DON and/or designee will audit that residents with wounds have weekly skin monitoring documented 3x/week x2 weeks, 2x/week x2 weeks, and weekly thereafter beginning the week of 03/24/25. 8. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 9. RN Case Manager will review and update R38 orders and care plan to ensure it addresses the order for ACE Wraps and who is responsible for applying/removing them. 10. All residents with orders for ACE Wraps have potential to be affected by this deficient practice. 11. All residents with orders for ACE Wraps will be reviewed by the RN Case Manager and/or designee to ensure their orders and care plan identify use of ACE Wraps and who is responsible for applying/removing them. 12. The Skin Integrity policy was reviewed by the DON on 03/17/25 with no changes needed. 13. All nursing staff will be educated by the DON and/or designee on the Skin	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 20 R18's N Adv - Skin Check dated 12/12/24 at 2:43 p.m., identified bruising purple and red inner lower right leg approximately 18 centimeter (cm) x 10 cm, warm with dark purple raised area in middle of 2 cm x 2 cm, skin intact. R18's Order Summary Report dated 12/14/24, identified treatment for open wound on right upper calf shallow crater: With minimal drainage, apply generous layer of protective ointment/ Bacitracin Zinc (an antibiotic ointment). Cover with non-adherent foam dressing. Secure with rolled gauze. Change every other day. R18's Skin/Wound note dated 12/19/24 at 7:30 a.m., identified the hematoma on R18's right leg broke open during the night and bled all over her bed. Old dressing was taken off and the swelling had gone down, and copious amounts old blood was draining from the wound. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/19/24 at 5:03 p.m., identified wound dressing to R18's lower right extremity was changed again this afternoon due to bleeding through the dressing. Copious amounts of old blood were coming out of the hematoma wound itself. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/21/24 at 1:02 a.m., identified changed wound dressing to R18's right lower extremity due to bleeding through the dressing. The wound to mid-calf had copious amounts of serosanguineous drainage saturating the dressing. R18 tolerated dressing change	F 684	Integrity Policy, including applying ACE Wraps, per resident order/plan of care. 14. DON and/or designee will audit that residents with ACE Wraps will have them applied per order/plan of care documented 3x/week x2 weeks, 2x/week x2 weeks, and weekly thereafter beginning the week of 03/24/25. 15. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 21	F 684		

without concern or complaint. The note failed to identify if R18's physician was notified of R18's change in condition.

R18's Skin/Wound note dated 12/21/24 at 10:27 a.m., identified R18 got a shower that morning. Dressing to R18's wounds on her right leg were changed and redressed. Hematoma did not have any drainage on old dressing but skin tear near the ankle had a small amount of greenish drainage noted on old dressing. The note failed to identify if R18's physician was notified of R18's change in condition.

R18's nursing progress note dated 12/26/24 at 12:18 p.m., identified R18 had been out for both meals that morning. R18 denied any pain, unless she bumped her right leg on something. No new injuries or new bruises have been noted. Dressing to her right lower extremity continued to drain and did have an odor to it. The note failed to identify if R18's physician was notified of R18's change in condition.

R18's Transfer Out of Building note dated 12/23/24 at 2:52 p.m., identified dressing change was being done on right skin, wound appears to be worsening, a photo was sent to the MD and per MD, R18 sent to the ER.

R18's Hospital Discharge Summary dated 12/30/24, identified R18 presented from outside ER, for surgical management of her right lower extremity wound. R18 had a fall about a month ago and developed a hematoma. About two weeks ago, R18 started having drainage from that wound. R18 was transferred to the ER yesterday because of worsening wound and purulent discharge. R18 does not remember, she

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 22 had underlying dementia and was not able to provide any history. Right lower extremity wound with purulent (consisting of, containing, or discharging pus) drainage. R18 underwent debridement (the surgical process of removing dead skin and foreign material from a wound. This can help to reduce the risk of infection and promote healing) on 12/25/24. R18's CT (a series of X-rays and a computer to create detailed images of your bones and soft tissues) shows soft tissue defect (refer to localized or multifocal pathologic syndromes involving the periarticular tissues, including muscle, tendon, ligament, fascia, aponeurosis, retinaculum, bursa, and subcutaneous tissue) involving medial mid lower leg 6 cm x 1.7 cm. Antibiotics were previously, vancomycin cefepime and Flagyl. Most recently on cephalexin. Wound culture over the weekend showed MRSA (Methicillin-resistant Staphylococcus aureus) (a type of bacteria that many antibiotics don ' t work on) and Morganella (a species of Gram-negative bacteria. It has a commensal relationship within the intestinal tracts of humans, mammals, and reptiles as normal flora. Although M. morganii has a wide distribution, it is considered an uncommon cause of community-acquired infection, and it is most often encountered in postoperative and other nosocomial (acquired while admitted to a health-care facility) infections), both sensitive to treatment. During a phone interview on 2/27/25 at 12:02 p.m., registered nurse (RN)-D stated R18 had a wound on her leg that R18 had gotten during a fall in her room. It began as a large hematoma. It was about the size of a golf ball, hard to touch, deep dark purple in color. Staff did look at it, but didn't do anything else. RN-D was unsure when	F 684		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 23	F 684		

but was told by another RN, the area had broken open. RN-D wasn't sure if R18 had bumped it or if it opened on its own, but it started to "bleed out". The RN had said there was more underneath it. RN-D stated she couldn't remember the exact details but R18 had gone to the emergency room and was transferred to another hospital from there. When R18 returned from the hospital, R18 had a wound vac (vacuum-assisted closure) is a therapeutic technique used to promote healing in acute or chronic wounds and burns. It involves using a suction pump, tubing, and a dressing to remove excess exudate, reduce swelling, clean the wound, and remove bacteria.) and declined a lot from there.

During an interview on 2/27/25 at 1:09 p.m., RN-E stated R18 was hospitalized due to an open wound and came back with a wound vac. However, RN-E stated she was aware of the where the original injury that caused the wound came from.

During an interview on 2/27/25 at 1:40 p.m., RN-A stated she responsible for the facility's wound care. RN-A was not aware of R18's wound until 12/12/24. The MD was in the building and RN-A asked for the MD to evaluated R18. Point of care (POC) treatment (measuring and monitoring) was ordered. Then, on 12/19/24, the deep tissue injury opened. RN-A was not working that day and RN-A was not informed until 12/23/24. RN-A contacted the MD and received an order to send R18 to the emergency room for evaluation. RN-A stated the on-call RN should have contacted the physician on 12/19/24 to update on R18's condition and request dressing orders. Further, RN-A stated she should have been informed of R18's tissue injury on 11/22/24 so the area could

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 24 be monitored and cared for appropriately. During a phone interview on 2/27/25 at 2:43 p.m., the MD stated he was not R18's primary physician but was the medical director for the facility. The MD did evaluate R18 on 12/12/24 and R18 had a large hematoma to the upper right shin. The area was not warm to the touch or open. The MD recommended monitoring the area for changes. The MD then was notified on 12/19/24, R18's hematoma had opened and the MD recommended transfer to the emergency room for evaluation. Normally, the MD would expect staff to contact the primary physician unless the physician was unavailable and to do so on 12/19/24 when R18's condition had changed. MD was not sure if the outcome would have been different for R18. During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated an injury should be followed and documented daily and/or when there were changes. The physician should have been notified on 12/19/24 when R18's condition had changed. The facility policy Skin Integrity dated 11/26/24, identified nursing staff will monitor resident's skin integrity and address issues promptly while providing care and services consistent with professional standards of practice. NEW SKIN INTEGRITY ISSUE A. Care center staff will notify the licensed nurse when a new skin integrity issue is observed. B. Licensed nurse will: a. Assess the area and identify the cause, if possible. b. Remove any source of pressure or trauma to the area.	F 684		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 25 c. Clean the area and provide treatment per care center House Standing Orders. d. Determine if the skin integrity issue is reportable to the State Agency (SA). If yes, notify the Administrator and Director of Nursing and proceed with the SA reporting process. (CCEP.MP.005 Maltreatment Investigation & Reporting) e. Complete a Skin Incident report in the resident EHR. f. Notify resident and/or responsible party. g. Notify Provider and request treatment orders, if applicable. h. Notify the Nurse Manager, Wound Nurse, or designee. i. Initiate a new tissue tolerance for any newly opened area or redness. j. Initiate appropriate preventive measures based on the immediate root cause. C. Nurse Manager, Wound Nurse, or designee will assess and complete a root cause analysis. D. Interdisciplinary Team (IDT) will review the skin incident report and evaluation of root cause for further recommendations. E. Provider will review, to diagnosis, if root cause was not related to an injury (i.e., skin tear, bruise), make recommendations, and/or initiate order(s). F. Nurse Manager, Wound Nurse, or designee will review/update the resident's current care plan. Intervention(s) will be initiated, as needed, based on resident/representative input, assessments, and Provider orders. MONITORING A. A licensed nurse will complete the skin check weekly and documented in the EHR. B. Nurse Manager, Wound Nurse, or designee will assess all applicable wounds weekly including pressure ulcers, venous ulcers, arterial ulcers,	F 684		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 26 diabetic ulcers, MASD, other wounds of concern. a. Documentation will be completed in the resident electronic health record and will include describing the following characteristics: i. Location ii. Stage if pressure ulcer iii. Measurements, including any undermining or tunneling/sinus tract. iv. Exudate v. Pain vi. Wound bed vii. Wound edges and surrounding tissue viii. Signs and symptoms of infection ix. Progress towards healing x. Current interventions, including treatment, and any changes made to plan of care. b. Provider will be notified of any significant changes and/or a delay in healing. C. Licensed Nurse will observe and measure weekly all skin integrity issues that are not followed by the Nurse Manager, Wound Nurse, or designee. a. Documentation will be completed in the EHR and will include escribing the following characteristics: i. Location ii. Measurements iii. Exudate iv. Pain v. Signs and symptoms of infection vi. Progress toward healing b. If any significant changes are observed and/or delay in healing, notify the Nurse Manager, Wound Nurse, or designee and Provider. D. Licensed Nurse will observe changes in skin integrity and treatments. Will notify the Nurse Manager, Wound Nurse, or designee with any changes. E. Pressure ulcers will be observed daily by the	F 684		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 27 licensed nurse. Documentation will include: a. Evaluation of pressure ulcer if no dressing present. b. Evaluation of the status of the dressing if present (intact, draining, and/or leaking). c. Status of area surrounding (observed without removing dressing). d. Presence of complications (i.e., increasing size, drainage, redness, swelling). e. Pain, if present, adequately controlled. F. Nurse Manager, Wound Nurse, or designee will update resident and/or representative with any significant change G. Provider to assess wound(s) during routine visits and will make any referrals, recommendations, or treatment changes based on assessment/evaluation. H. Care center may utilize wound care specialists. I. Nurse Manager, Wound Nurse, or designee will track and trend skin integrity issues. Tracking and trending reports will be included in QAPI meetings. If the QAPI committee identifies significant causative factors and/or specific trends and patterns, measures will be taken to correct the identified areas. R38: R38's admission MDS dated 2/12/25, identified R38 had intact cognition and required maximum assistance with dressing and grooming. R38 was dependent on staff for toileting, and transfers. Diagnoses included hemiplegia following cerebrovascular disease and venous insufficiency. R38's care plan dated 2/11/25, identified R38	F 684		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 28 received diuretic therapy for edema (swelling) and hypertension. Interventions included to administer diuretic medications as ordered and monitor for effectiveness and side effects. The care plan also included a focus that R38 had a diagnosis of peripheral vascular disease. Interventions included to educate on importance of proper foot care, elevate legs when sitting or sleeping and to monitor for excessive edema. R38's Order Summary Report dated 2/26/25, identified an order to apply Ace Wraps to his legs each morning before getting out of bed and to remove the wraps at bedtime. The care plan did not idenitfy the Ace Wraps were ordered or who was respondible for applying them. On 2/24/25, at 1:05 p.m. R38 was observed sitting in his wheelchair in his room watching television. R38's legs and feet were in a dependent position with his feet resting on the wheelchair foot pedals and had visible edema present on both his legs, from his knees to his feet. R38 stated the swelling in his legs was not a new problem for him but the doctor had recently ordered wraps to his legs for the swelling. Two long Ace Wraps were resting on R38's bedside table in a pile. R38 stated the staff did not put them on that morning and he was not sure why they had not been applied. On 2/25/25, at 10:58 a.m. R38 was again seated in his wheelchair in his room watching television. R38 was fully dressed and his legs and feet were in a dependent position with his feet resting on the wheelchair foot pedals. Edema was visibly present on both legs and feet. Ace Wraps were observed on R38's bedside table. R38 stated he did not know why staff had not applied the wraps	F 684		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 29 to his legs when assisting him that morning. When interviewed on 2/25/25, at 11:25 a.m. nursing assistant (NA)-E stated she had assisted R38 to get dressed that morning. She did not put R38's Ace Wraps on as that was the nurses duty to do them. NA-E had not even known R38 needed wraps to his legs but she had seen them in his room that morning. During interview on 2/25/25, at 11:26 a.m. licensed practical nurse (LPN)-A stated R38 was supposed to have Ace Wraps on his legs. LPN-A had not been able to get to R38 yet. LPN-A stated R38 really should have them on before he gets out of bed in the morning. Wrapping his legs should be scheduled for night shift to do in the morning, as R38 was usually up and dressed before the day shift got out of report and she planned to change the scheduled time so it would not get missed again. During interview on 2/27/25, at 9:44 a.m. registered nurse (RN)-B stated R38's Ace Wraps should be applied daily and done before he got out of bed in the mornings. RN-B stated the problem with not putting the wraps on before he got up was that his legs tended to swell up quickly and if you waited to long, the swelling would have already happened. During interview on 2/27/25, at 2:12 p.m. the director of nursing (DON) stated she would have expected staff to apply R38's wraps as ordered prior to getting up in the mornings. The wraps were ordered to decrease the inflammation and dependent edema in R38's legs and feet. The facility policy Skin Integrity dated 11/26/24,	F 684		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 684	Continued From page 30 identified nursing staff would monitor resident's skin integrity and address issues promptly while providing care and services consistent with professional standards of practice.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 1 of 2 residents (R4); and failed to follow pressure ulcer treatments as ordered to promote healing for 1 of 2 residents (R31) reviewed for pressure ulcers.. Findings include: R4: R4's quarterly Minimum Data Set (MDS) dated 1/3/25, identified R4 was cognitively intact and had diagnoses that included peripheral neuropathy (occurs when the nerves located	F 686	1. RN Case Manager will assess R4 skin for any new skin alterations. 2. All nursing staff will be educated on R4 repositioning plan by the DON and/or designee. 3. All residents who need assistance with repositioning have the potential to be affected by this deficient practice. 4. DON and/or designee will audit all residents who need assistance with repositioning, repositioning care plans to ensure accuracy. 5. DON reviewed the Repositioning Policy on 3/17/25 with no changes needed.	3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 686	Continued From page 31 outside of the brain and spinal cord are damaged. It often causes weakness, numbness, and pain, typically in the hands and feet, but can also affect other areas and body functions. It is common in people with diabetes.), type 2 diabetes, congestive heart failure (CHF), venous insufficiency (occurs when the valves in the veins become damaged, allowing blood to flow backward.), and dermatitis. R4 was at risk for pressure ulcer but had no open areas. R4's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 4/16/24, identified R4 was at risk for pressure ulcer/injury and pressure ulcer/injury would be addressed on R4's care plan. However, the CAA failed to identify an analysis of the findings. R4's Braden Scale for Predicting Pressure Ulcer Risk dated 1/3/25, identified R4 was at risk for pressure ulcer and did not include any interventions. R4's care plan revised 11/22/24, included an intervention of encouraging R4 to repositioning every two hours, and lay in bed to offload During a continuous observation on 2/26/25 at 8:26 a.m., nursing assistant (NA)-A and NA-G exited R4's room after assisting R4 with morning cares. R4 was sitting in her wheelchair. - At 8:31 a.m., R4 propelled her wheelchair to the dining room for breakfast. - At 9:16 a.m., R4 was finished with her breakfast meal and propelled her wheelchair to the activity room. No staff offered to reposition R4. - At 11:48 a.m., R4 propelled her wheelchair from the activity room to the med chart then propelled her wheelchair to common area off the dining	F 686	6. All nursing staff will be educated on the Repositioning Policy, including making sure residents are repositioned per care plan and documenting completion of turning and repositioning. 7. DON reviewed the Skin Integrity policy on 03/17/25 with no changes needed. 8. All nursing staff will be educated by the DON and/or designee on the Skin Integrity Policy, including following residents' interventions for preventing skin breakdown. 9. DON reviewed the Person-Centered Care Planning policy on 03/17/25 with no changes needed. 10. All registered nurses will be educated by the DON and/or designee on the Person-Centered Care Planning Policy, including following residents repositioning care plan interventions. 11. DON and/or designee will audit that residents who are on a repositioning schedule are repositioned per their care plan, including for R4, 3x/week x2 weeks, 2x/week x2 weeks, and weekly thereafter beginning the week of 03/24/25. 12. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 13. RN wound care nurse and/or designee will review R31s orders for wound care and ensure wound care is provided by licensed nurse per order. 14. DON and/or designee will educate the licensed nurses on completing wound care orders per R31s orders.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 686	Continued From page 32 room to watch tv. No staff offered to reposition R4. During an interview on 2/26/25 at 11:55 a.m., R4 stated she got up about 8:00 a.m. for breakfast and then went to the activity room for bible study. R4 was supposed to lay down or sit in her recliner every couple of hours. However, on 2/26/25, R4 had not laid down or sat in her recliner nor had staff offered. During an interview with NA-A and NA-G on 2/26/25 at 11:58 a.m., NA-G stated R4 was at risk for pressure ulcers, but the wound was healed "right now." Staff were supposed to offer repositioning every two hours to try to prevent the area re-opening. NA-G stated NA-G nor NA-A had offered repositioning because it had just been one of those days. During an interview on 2/26/25 at 12:07 p.m., registered nurse (RN)-A stated staff were to encourage R4 to reposition every two hours to prevent pressure ulcers. During an interview on 2/27/25 at 3:37 p.m., the director of nursing (DON) stated staff were expected to offer repositioning per the resident's care plan. R4 was at risk for skin breakdown and staff were expected to keep R4 clean and dry. R31: R31's quarterly MDS dated 11/27/24, identified R31 had intact cognition and required partial assistance with dressing. and bed mobility, and was dependent with toileting and bathing. R31 was at risk for pressure ulcer development and	F 686	15. All residents with wound treatments have potential to be affected by this deficient practice. 16. DON and/or designee will review other residents with wound care orders treatment records to ensure treatments were signed off as completed going back to 3/1/25. 17. DON reviewed the Skin Integrity policy on 03/17/25 with no changes needed. 18. All nursing staff will be educated by the DON and/or designee on the Skin Integrity Policy, including completing treatments as ordered to heal wounds and prevent infections and to sign off treatment orders in the electronic health record once completed. 19. DON and/or designee will audit that residents who have wound care orders have received their wound care as ordered and are signed off in the treatment record as completed, including R31, 3x/week x2 weeks, 2x/week x2 weeks, and weekly thereafter beginning the week of 03/24/25. 20. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 686	Continued From page 33 had one facility acquired stage two pressure ulcer and one facility acquired stage four pressure ulcer present. R31 also had one stage two pressure ulcer that was present on admission. R31's diagnoses included congestive heart failure, and diabetes. R31's careplan dated 11/25/24, identified R31 had actual impairment to skin integrity of the left back calf and right heel related to deep tissue injury. Interventions included to elevate left leg so the wound would not touch the bed, float heels, use lambs wool under legs and feet, turn and reposition every two to three hours, and observe skin daily with cares, R31's Order Summary Report dated 2/27/25, directed staff to complete daily monitoring and documentation every shift for pressure ulcers located on right heel, left ankle and left mid calf. Physician ordered right heel wound care and left calf wound care included to remove wound dressing to both wounds, irrigate the wounds with sterile water, pat dry, apply a woven gauze wet to dry dressing and wrap both wounds with rolled gauze daily. On 2/25/25, at 3:03 p.m. registered nurse (RN)-A entered R31's room after putting on a gown, gloves and mask. RN-A laid out the necessary supplies to complete R31's ordered wound care on a disposable pad on R31's bed stand. RN-A uncovered R31's leg and proceeded to remove the dressing on R31's left calf. The dressing was dated 2/23/25 with black marker, two days before. Gauze packing was removed from the wound and was saturated with dried, serosanguinous drainage. RN-A irrigated the wound with sterile water and applied the wet to dry gauze and rolled	F 686		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 686	Continued From page 34 gauze as ordered, dating the new dressing 2/25/25. After changing gloves, RN-A lifted R31's right leg up to assess his right heel. The heel was open to air, dry appearing serosanguinous drainage covered an eight inch area of the fitted sheet on the foot of the bed. A rolled gauze and folded gauze dressing was loosely wrapped around R31's right calf and was dated 2/23/25. RN-A cut off the old dressing that had slid up from R31's right heel wound. No drainage was visible on the old dressing. RN-A irrigated the right heel wound and applied the new dressing as ordered and dated the dressing 2/25/25. RN-A stated R31 must not have gotten his dressing changed the day before as ordered. R31's Treatment Administration Record (TAR) for February 2025, identified monitoring and documentation of right heel, left ankle and left mid calf pressure ulcers were not signed off completed on February 17, 19, 20, 22, and 25. Physician ordered daily dressing change to right heel had not been signed off completed for February 21, 22, and 25 Physician ordered daily dressing change to left calf had not been signed off completed on February 17,19, 20, 22, and 25. When interviewed on 2/27/25, at 9:28 RN-F stated if an order on a resident's TAR was not initialed she would assume that to mean it had not been done that day. During interview on 2/27/25, at 9:44 a.m. RN-B stated if an order on a resident's TAR was not initialed off it could mean it had not been done. R31's dressings needed to be completed daily so they could monitor for symptoms of infection and drainage and make sure his wounds were not getting any worse.	F 686		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 686	Continued From page 35 During interview on 2/27/25, at 2:12 p.m. the DON stated she expected R31's dressings to be completed daily as ordered to help R31's wounds heal and prevent infection. The facility policy Skin Integrity dated 11/26/24, identified the facility would assess each resident's risk for skin integrity issues at move in, quarterly, with any significant change in condition, and with a new or potential pressure ulcer and will identify interventions to help prevent skin integrity issues. Residents at risk for skin breakdown would have preventative measures implemented such as repositioning plan and pressure redistribution devices. The Care plan would address the resident needs, goals, and interventions based on the skin assessment and resident/representative input. Interventions will be implemented, reviewed, and updated for appropriateness. Further, pressure ulcers would be observed daily. Documentation would include evaluation of the pressure ulcer, evaluation of the status of the dressing, status of the surrounding area, presence of complications and pain if present.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 36 Based on observation, interview, and document review, the facility failed to comprehensively assess each fall to ensure interventions were followed; and failed to ensure fall interventions were care planned timely and implemented to prevent falls for 1 of 1 residents (R19) reviewed for falls. Findings include: R18's significant change Minimum Data Set (MDS) dated 1/6/25, identified R18 had a severe cognitive impairment and diagnoses that included Alzheimer's disease, dementia and osteoporosis. R18 had a fall without injury and a fall with injury. R18 did not use an alarm or any physical or electronic device that monitored R18's movement and alerted staff when movement was detected. R18's Falls Care Area Assessment (CAA) dated 1/6/25, identified R18's fall risk was 27; Score 10 or higher indicated R18 was at high risk of falls. R18 was currently assistance of one staff for all transfers with the use of a mechanical lift. R18 was not able to walk, was using a manual wheelchair. R18 was able to move herself around short distances in the wheelchair and was staff assist of 1 for longer distances. R18 often attempted standing independently, staff were monitoring her closely to intervene and prevent falls. OxyCODONE HCl (narcotic pain medication) Oral Tablet 5 miligram (MG) Give 0.5 tablet by mouth every 4 hours as needed for moderate to severe pain related to CELLULITIS OF RIGHT LOWER LIMB was Prescribed by when in hospital and R18 was currently taking it. The CAA identified R18's Falls - Functional Status would be care planned but provided no further information.	F 689	1. RN Case Manager will complete a new fall assessment for R18. 2. RN Case Manager will review R18 care plan to ensure it addresses individualized interventions for fall prevention based on fall assessment, including adding a toileting plan. 3. All residents at risk for falls have the potential to be affected by this deficient practice. 4. Fall Coordinator and/or designee to review all residents fall assessments who are at risk for falls for accuracy, a new assessment will be completed if needed. Safety care plans will be reviewed to ensure they are up to date based on the fall assessment. 5. DON reviewed the Person-Centered Care Planning policy on 03/17/25 with no changes needed. 6. All registered nurses will be educated by the DON and/or designee on the Person-Centered Care Planning Policy, including updating residents care plans timely with any changes. 7. All nursing staff will be educated by the DON and/or designee on the Person-Centered Care Planning Policy, including following interventions on the care plan. 8. DON reviewed the Fall Prevention and Management policy on 03/17/25 with no changes needed. 9. All registered nurses will be educated by the DON and/or designee on the Fall Prevention and Management policy, which addresses fall prevention. Education will include completing a fall assessment prior to developing and implementing	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 37 R18's care plan revised 2/6/25, identified R18 was at risk for all related to confusion. Interventions included: - Assist R18 as needed with mobility and transfers - Be sure R18's call light was within reach and encourage R18 to use it for assistance as needed. - Bed in lowest position - Ensure that R18 was wearing appropriate footwear shoes when up ambulating or mobilizing in wheelchair and gripper socks when in bed. - R18 did not remember that R18 needed assistance with transfer or ambulation, anticipate needs. - R18 had a Bed sensor on R18's wall. - R18 had an easy touch call light under sheet, under R18's hip on R18's bed. - R18 needed a safe environment with floors free from spills and/or clutter; personal items within reach, gripper strips on floor in front of bed, recliner, and toilet - Keep R18 wheelchair next to R18 during meals and activities - R18 fall risk would be assessed every quarter and with change in condition However, the care plan failed to identify toileting as an intervention. R18's Incident Forms identified the following: - 11/7/24 at 8:45 a.m., identified R18 was heard yelling out for help, she was found lying on the floor in the hallway off the dining room. R18 was laying on the floor, laying on her right side. R18 stated she was walking to eat, and her knees just gave out and she fell to her knees and then fell to her right side. R18 would have been in bed three	F 689	appropriate interventions. 10. DON and/or designee will audit that new fall interventions are added to the resident's care plan on the same shift 3x/week x2 weeks, 2x/week x2 weeks, and weekly thereafter beginning the week of 03/24/25. 11. DON and/or designee will audit that fall interventions are occurring per care plan 3x/week x 2weeks, 2x/week x 2 weeks, then weekly thereafter beginning the week of 3/24/25. 12. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 38	F 689		

hours prior to fall. At 7:30 a.m., staff walked resident out to the dining room for breakfast. R18 was evaluated in the emergency room. Fall interventions included: physician reviewed medications, continue with present care plan, staff to offer to assist back to room when done with meals. However, the care plan was not revised to reflect this.

- 11/15/24 at 3:00 p.m., R18 was laying against the entry door. Her walker was tipped over and laying against the door as well. R18's closet doors were both open and a pair of pants, still on the hanger were laying on the floor. R18 had her shoes on her feet. R18 stated that she was trying to get clothes to go in the bathroom and change. R18 was incontinent at the time of the fall. Vitals were taken and R18 was assessed. R18 does have a small hematoma on the back of her head. No other visible injuries and R18 did not have any complain of pain or discomfort. R18 was last toileted at 11:30 a.m.(3.5 hours prior). R18 was alert and oriented to her baseline, making jokes about falling on the floor. ROM was normal in both upper and lower extremities. Resident will be reviewed at the next High-Risk meeting. Fall interventions included toilet every two hours and follow care plan. However, the care plan was not revised to reflect this.

- 11/22/24 at 1:15 a.m., identified a loud scream was heard and then a crash. R18 was found almost up against the door. Staff had to push the door open until staff could fit through. Stepped over R18's walker. R18 was sitting up against her closet and was confused. R18 stated she was just getting up. R18 did say she hurt everywhere. A quick exam was done. R18 asked to be put back to bed. When R18 was put in bed, the

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 39 nursing assistant noted a big, black bruised lump on R18's right inner shin. R18 continued to say she hurt everywhere. Vitals were obtained while phones calls where made to R18's son. R18 was sent to the ER for evaluation. Fall intervention included a flat sensor placed under sheet under hip. However, the care plan was not revised to reflect this until 12/3/24. - 11/22/24 at 11:40 p.m., identified R18 was found lying on her left side next to her bed. Her head was positioned near the bed and her feet were towards the middle of the room. R18 had a UTI and is being treated with Cefdinir (an antibiotic) 300 miligram (mg) twice a day for 10 days. R18 had several falls recently and did have bruises from said falls. Palpated R18's head and did not find any lumps, bumps, or sore areas. R18 did have redness to left hip area. R18 denied any new pain but with dementia diagnosis R18 was not a reliable reporter/historian. R18's fall will be followed up at next High Risk Committee meeting. The Incident Form also identified staff were unsure sensor alarm was working due to no staff at the nursing station. Fall interventions included to place flat sensor under sheet under hip on bed. Referred to maintanence to order. However, the care plan was not revised to reflect this until 12/3/24. - 12/22/24 at 10:10 p.m., identified staff heard yelling and found R18 on the floor lying between closet and dresser with head close to the wall/feet pointing toward her bed. R18 was on her right side with her legs positioned under her wheelchair. R18 had right shoe on/left shoe off. Resident has dementia and was unable to tell staff what she was doing/where she was going. R18 reported that she hit her head. No bumps,	F 689		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 40 lumps or sore areas found on her head. She c/o rt hip pain while on the floor but denied pain when in bed. However, the form failed to identify interventions implemented or if staff failed to follow the care plan. - 1/31/25 at 4:11 p.m., R18 sat herself up on the edge of her bed without staff assistance and no shoes on. R18 slid from the edge of her bed to the floor with her back to the bed. Nursing assistant was rounding on residents and found R18 sitting on the floor with her back to the bed. R18 was sitting there looking as though she sat there and was just leaning against the bed. R18 had socks on her feet and no shoes on. When asked what happened R18 stated, "I was sitting on the edge of the bed and slid right of onto my butt, the bed was slippery and I didn't have my shoes on, so my socks were slippery too". Resident was assessed no Injuries noted. However, the form failed to identify interventions implemented or if staff failed to follow the care plan. During a continuous observation 2/26/25 at 9:38 a.m., R18 was assisted to lie down in bed by nursing assistant (NA)-A. NA-A did not offer toileting to R18. During an interview on 2/26/25 at 9:41 a.m., NA-A stated she did not offer toileting to R18. R18 was usually pretty continent and would say if R18 needed to use the toilet. During an interview on 2/27/25 at 11:06 a.m., NA-G stated R18 was a fall risk. R18 had a sensor in her room that told them when R18's moving and also has a touchpad call light that staff tucked under R18's side when R18 was in	F 689		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 41	F 689		

bed. R18 was pretty continent and did not go very often so staff did not toilet R18 every two hours.

During a phone interview on 2/27/25 at 12:02 p.m., registered nurse (RN)-D stated R18 was a fall risk. R18 had a sensor on the wall in her room that told staff whenever there was movement in the room. R18 also had a touchpad call light on her mattress so if R18 tried to get out of bed it would let staff know. R18 needed to be toileted every two hours. R18 could tell staff too but R18 needed to be toileted every two hours. R18 hasn't tried to get out of bed since she came back from the hospital but R18 still had the sensors in her room.

During an interview on 2/27/25 at 12:55 p.m., RN-F stated when a resident fell, an incident report was completed during the High Risk meeting, then RN-E updated the resident's care plan. R18 was a fall risk. R18 needed toileting every two hours and was able to tell you if R18 needed to go but needed help getting to and from the toilet. Staff should always offer toileting. RN-E stated R18 had memory loss and R18 might not think of it in time. It was safer for R18 to toilet, especially before lying down, because R18 wasn't waking up and trying to get out of bed. R18 did not always remember to use her call light.

During an interivew on 2/27/25 at 1:09 p.m., RN-E stated R18 was at risk for falls and R18's care plan was not revised to reflect toileting every two hours and/or for staff to assist R18 back to her room after meals.

During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated staff were expected to revise resident care plans with

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 689	Continued From page 42 identified fall interventions and were expected to follow the care plans to attempt to prevent further falls. A facility policy regarding fall prevention was requested but not received.	F 689		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess for trauma informed care and identify potential triggers, to avoid potential re-traumatization for 1 of 1 residents (R7) reviewed for trauma informed care. Findings include: R7's quarterly Minimum Data Set (MDS) dated 12/9/24, identified R7 was cognitively intact and had diagnoses of post traumatic stress disorder (PTSD), anxiety, insomnia, and bipolar disorder (a mental illness characterized by extreme mood swings). R7's psychosocial well-being Care Area Assessment (CAA) dated 3/25/24, failed to identify an analysis and/or goal.	F 699	1. Social Services Designee completed a Trauma Informed Care Assessment with R7 on 03/05/25. 2. Social Services Designee revised R7s care plan on 03/13/25 to reflect past trauma and individualized interventions and triggers. 3. All residents who have suffered past trauma have the potential to be affected by this deficient practice. 4. Activity Director will audit all current residents to ensure that they have had a Trauma Informed Care assessment completed. If they did not, the Activity Director will complete one and update their care plan as needed. 5. DON will educate Social Services Designee on the Trauma Informed Care policy.	3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 699	Continued From page 43 R7's Social Services Quarterly Note dated 12/9/24, identified R7 had no change in status. R7 was currently receiving psychoactive medications and psychological/psychiatric services were currently indicated. R7's Behavior Assessment dated 12/9/24, identified R7 became very upset with staff and aimed her anger toward one staff person, yelling at them, calling them names and refusing them to provide R7 with care. R7 was known to refuse cares which put R7 at risk for skin break down due to being incontinent of both bladder and bowel. These behaviors were caused by R7 feeling she was not being listened to or respected. Staff were directed to provide 1:1 time, conversation and change in caregivers. Leave room when R7 upset and calmly reapproach R7 later. R7's care plan revised 1/17/25, identified R7 had a behavior problem requesting task from staff, then refused when staff attempted to provide related to anxiety and depression. The following interventions were identified: - Two staff at all times when in R7's room. - Ask R7 if there was anything R7 needed/reason for calling out/disruptive noises. - Anticipate and meet R7's needs. - Document in tasks that were completed or refused. - Document outside R7's room the time you enter/leave room - Explain all procedures to R7 before starting and allow R7 to adjust to changes. Tell R7 going change her, reposition or when need to touch R7 with cares. - R7 was either elated or upset not happy with	F 699	6. DON reviewed the Trauma Informed Care Policy on 03/17/25 with no changes needed. 7. DON or designee will perform an audit to ensure all residents receive a Trauma assessment on admission and when exhibiting new signs of past trauma 3x/week x2 weeks, 2x/week x2 weeks, and weekly thereafter beginning the week of 03/24/25. 8. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 699	Continued From page 44 anything when R7 asked for assist. Then will refuse to allow staff to assist R7. R7 yelled with cares, will make false statements of abuse by staff. Requested for staff numerous times to R7 room, then wanting them to come back later. R7 wanted instant gratification. - If reasonable, discuss R7's behavior. Explain/reinforce why behavior was inappropriate and/or unacceptable. - Leave and return later to complete R7's cares - Leave R7 alone to calm down when R7 was yelling/screaming at staff. Once had calmed down return to address any concerns. However, the care plan failed to identify R7's PTSD triggers and/or interventions specific to his PTSD. R7's medical record failed to identify a Trauma-Informed Care Assessment was completed. During an interview on 2/26/25 at 1:55 p.m., the activities director (AD) stated she was the facility social worker. AD stated R7 did not have a Trauma Informed Care Assessment in her medical record. AD had recently learned that she was responsible to complete that assessment and had done so for another resident. The purpose of the assessment was to let the facility staff know of a history of abuse, any traumatic events in a resident's life that could potential trigger a memory or event or unwanted care. Basically to be aware of things that could be not good or unpleasant for a resident. R7 had a history of childhood sexual abuse. AD stated R7's care plan did not identify R7 had PTSD nor did the care plan identify triggers that could be unpleasant for R7 such as a male caregiver. During cares, especially during pericares, staff	F 699		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 699	Continued From page 45	F 699		

had to be diligent to tell R7 what was going to hapen. A second person was always in the room because R7 had a history of false accusations towards staff.

During an interview on 2/27/25 at 3:30 p.m., the director of nursing (DON) stated a Trauma Informed Care Assessment should be completed because it ensured staff individualized treatment for R7 and also ensure R7 received the extra care and services R7 might need

The facility policy Trauma Informed Care revised 9/11/23, identified the facility would ensure residents who are trauma survivors receive culturally competent, trauma informed care in accordance with professional standards of practice. The procedure directed the following:
A. The care center will use a multi-faceted approach to identify a resident's history of trauma through:
a. Admission assessment, including a screening tool for trauma, by interviewing the resident and/or their representative
b. History and physical
c. Social history and assessment
d. Review of medical records
e. Interview of primary care physician
f. Observation of behaviors that may indicate past trauma
B. Care centers will use a universal screening tool to identify previous trauma emphasizing the value of culture and diversity of others.
a. The screening tool for trauma will be completed as an assessment in the electronic medical record (Trauma-Informed Care: Resident/Trauma-Informed Care: Responsible Party) by Social Services (or designee) with the resident and/or their representative on

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 699	Continued From page 46 admission or when behaviors may indicate past trauma. C. Care planning of resident centered behavioral health approaches and goals will be completed in response to the screening or when identified on periodic assessment of resident survivor. Care plan goals and approaches will include individual preferences and routines in response to the emotional and psychosocial needs of the resident survivor. D. If trauma is identified within 48 hours of admission, interventions will be added to the baseline care plan to address the trauma until completion of the comprehensive care plan. E. The interdisciplinary team will ensure that the resident survivor receives appropriate services and treatments. Community resources will be utilized as needed. F. Trauma Informed Care competency training will be completed upon hire and annually with all staff providing services to resident survivors.	F 699		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 732	Continued From page 47 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a posting was updated daily and ensure the census was on the nurse staff posting. This had the potential to effect all 38 residents residing in the facility and/or visitors who may wish to view the information. Findings include: During an observation on 2/21/25 at 1:06 p.m., the facility nurse staff posting was on the wall near the front entrance. The nurse staff posting was dated 2/21/25, indicated a census of 38 and included information on scheduled shifts for nursing staff along with the number of staff	F 732	1. DON reviewed the Nursing Staff Posting policy on 03/17/25 with no changes needed. 2. All residents and visitors have the potential to be affected by this deficient practice. 3. All licensed nurses will be educated on the Nursing Staff Posting policy and the need to update the posting as staffing numbers change. 4. DON or designee will perform an audit to ensure the Nursing Staffing Posting is up to date 3x/week x2 weeks, 2x/week x2 weeks, and weekly thereafter beginning the week of 03/24/25.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 732	Continued From page 48 assigned to the shift with total hours worked. During an observation on 2/25/25 at 3:17 p.m., the nurse staff posting continued to be dated 2/21/25. The director of nursing (DON) stated she did not know who was responsible to complete, update and post the nurse staff posting. The nurse staff postings were reviewed from 1/19/25 through 2/25/25. The nurse staff postings were not updated with actual working staff hours on the following 12 days: 1/19/25, 1/20/25, 1/23/25, 1/24/25, 2/1/25, 2/2/25, 2/3/25, 2/15/25, 2/16/25, 2/17/25, 2/20/25 and 2/21/25.The facility census was not recorded on the following 26 days: 1/21/25, 1/22/25, 1/25/25, 1/26/25, 1/27/25, 1/28/25, 1/29/25, 1/30/25, 1/31/25, 2/4/25, 2/5/25, 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/10/25, 2/11/25, 2/12/25, 2/13/25, 2/14/25, 2/18/25, 2/19/25, 2/22/25, 2/23/25, 2/24/25, and 2/25/25. During an interview on 2/25/25 at 3:24 p.m., the DON stated night shift staff were responsible to complete the nurse staff posting and each shift's nurse was responsible to update the posting to reflect staffing changes, which was not consistently being done. Staff were expected to ensure the completion and posting of the nurse staff posting and update the nurse staff posting throughout the day to reflect staffing changing because it was for resident and/or visitors use. The facility policy Nursing Staff Posting undated, identified the following: 1. The Night Charge Nurse will count daily the number of nursing staff directly responsible for resident care. 2. The information will indicate the number of	F 732	5. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 732	Continued From page 49 RN's, LPN's, and NAR's working on each shift for the day. 3. It will also include the facility census at the start of the day. 4. The information will be updated as needed in response to call-in, traded shifts, absences, etc. 5. Census information will be updated as needed with admissions and discharges. 6. The information will be posted by the main entrance. 7. Previous postings will be kept in the Medication Room. 8. The information will be kept for eighteen (18) months.	F 732		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess dementia related behaviors and implement appropriate interventions to minimize verbal and physical resident to resident altercations for 1 of 2 residents (R22) reviewed for dementia care. Findings include: R22's admission Minimum Data Set (MDS) dated 1/17/25, identified R22 had severe cognitive impairment and required supervision with activities of daily living (ADLs). R22 exhibited delusions, physical and verbal behaviors	F 744	1. RN Case Manager will complete a behavior assessment for R22 and update their care plan interventions based on the assessment. 2. All residents with dementia have the potential to be affected by this deficient practice. 3. All residents with diagnosis of dementia electronic health record documentation will be audited for verbal and/or physical behaviors towards other residents by the Activity Director and/or designee. If any residents have dx dementia with verbal and/or physical	3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 744	Continued From page 50 symptoms directed toward others daily, as well as other behavioral symptoms such as pacing, rummaging and verbal symptoms. R22's behavioral symptoms significantly impacted his care as well as put others at significant risk for physical injury, intruded on their privacy and disrupted care and living environments. R22 rejected care and wandered daily. Diagnoses included neurocognitive disorder with lewy bodies, and heart disease. R22's Behavior Care Area Assessment dated 1/17/25, identified R22 had a diagnosis of lewy body dementia and was very paranoid. R22 verbally threatened to kill other residents, staff and his wife. R22 pushed and hit staff. R22 wandered continuously, was intrusive to other residents and staff and was difficult to redirect. R22 was on antipsychotic, antidepressant and antianxiety medications. R22's Cognitive Loss/Dementia Care Area Assessment dated 1/17/25, identified R22 had severe cognitivie impairment and a diagnosis of lewy body dementia with behaviors. R22's care plan revised on 2/17/25, identified a focus R38 would not harm self or others with a goal R38 would remain safe. Interventions included to approach him by his side when upset, do not talk about his wife or tell him no. If poses a threat to injure self or others, staff were to notify provider and approach with one to two persons calmly, from his side and call by name. maintain a consistent schedule, minimize environmental stimuli, monitor for factors that may contribute to violent behaviors, remove from conflict with other residents and utilize diversional techniques such as 1;1, short word sentences, take for a walk or	F 744	behaviors towards others, Activity Director will ensure they have a behavior assessment and that care plan interventions for behaviors are up to date. 4. DON reviewed the Person-Centered Care Planning policy on 03/17/25 with no changes needed. 5. DON and/or designee will educate RN Case Managers on the Person-centered Care Planning policy and management of behaviors. 6. DON reviewed the Dementia Care Policy on 03/17/25 with no changes needed. 7. DON and/or designee will educate all nursing staff on the Dementia Care policy. 8. DON reviewed the Maltreatment of Vulnerable Adults Reporting policy on 03/17/25 with no changes needed. 9. DON and/or designee will educate all staff on the Maltreatment of Vulnerable Adults Reporting policy. 10. DON and/or designee will educate licensed nurses on filling out an incident report for negative resident to resident interactions. 11. If any resident has a resident-to-resident altercation, the Social Services Director or RN Case Manager will reassess the resident(s) behaviors and update the care plan interventions as needed. IDT will review all resident-to-resident altercations, identify a root cause, and make recommendations for individualized interventions to prevent recurrence. 12. RN Case Manager will complete a Behavior Assessment on all residents on admission, quarterly for all resident's	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 744	Continued From page 51 offer an activity. Another focus on the care plan was behaviors problems physically aggressive to staff evidence by pushed, grab, yell, shake fist or abrupt approaches. Staff were to utilize the same interventions as well as explain procedures before starting, get help from other staff when necessary, monitor behaviors to attempt to determine underlying cause, redirect with distraction such as food., and intervene immediately during any negative interaction R22 was involved in. R22's care plan failed to identify his behaviors toward other residents in the facility or directed interventions to address the resident to resident incidents when they occurred. During observation on 2/24/25, at 5:55 p.m. R22 was pacing in the halls and dining room in an hurried manner, pushing at staff who were walking along with him. Two unidentified staff attempted to get R22 to return to his room without success and stopped when R22 struck out and pushed them away. An unidentified staff member dressed in gown, gloves and mask stayed beside R22 as he paced around residents in the dining area. At 6:18 p.m. R22 sat with the staff member, at a table in dining area eating a snack. Residents residing in the facility identfied the following concerns related to R22's behaviors: During interview on 2/24/25, at 1:30 p.m. R38 stated R22 had entered his room and woke him up in the early morning, taking things off his table. R38 stated if you tried to stop R22 from taking items R22 got mad. R22 would ball up his fist like he was going to punch but he never had. Staff had been chasing after R22 and came in behind him and got him out of R38's room. R38's	F 744	exhibiting behaviors, and when a resident has any new behaviors. 13. DON or designee will perform an audit to ensure all residents receive a behavior assessment on admission, quarterly for residents with behaviors, and when exhibiting new behaviors 3x/week x2 weeks, 2x/week x2 weeks, and weekly thereafter beginning the week of 03/24/25. 14. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 744	Continued From page 52 admission MDS dated 2/12/25, identified R38 had intact cognition. When interviewed on 2/24/25, at 2:54 p.m. R36 stated R22 would chase female staff and residents. R22 had chased them down the hall waving a four footed cane at them. R22 tried to shake that cane at R36 on one occasion., when R36 walked by R22 and noticed R22 had dropped his cookies, so R36 retrieved the cookies and handed them back to R22. R22 became mad and bunched up his fist, threatening to punch R36. R36 stated he just took his cane and held R22's arm against his chest with it and told him not to threaten to punch him and then changed the subject to distract him. R36's admission MDS dated 2/11/25, identified R36 had intact cognition During interview on 2/25/25, at 11:13 a.m. R28 stated R22 did not like her and every time he saw her he would shake his fist at her and threaten to punch. R28 though it was because she always hollered at R22 to get out of her room when he wandered in. Once, she had shut her room door to keep him from getting in and he kicked and banged on her door angrily to try to get it back open. The facility had told her they were trying to find some where else for R22 to go. R28's quarterly MDS dated 12/10/24, identified R28 had intact cognition R22's progress notes identified the following: - 1/12/25, R22 walked up behind another resident sitting in a chair in the dining room and attempted to tip the chair backwards with the other resident in the chair. The resident hollered and told him to stop. R22 became agitated. Staff intervened and sat at the table with the residents until they calmed down.	F 744		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 744	Continued From page 53 - 1/19/25, R22 was approached by another male resident who leaned down and punched R22 in the stomach. R22 then punched the male resident back. Staff were present and separated the residents. - 2/4/25, R22 stated he was knocking on another resident's door when she opened it and slammed it, yelling at him, and the door hit R22 in the nose. This made R22 angry and he started kicking at the door. - 2/8/25, R22 had been going up behind other residents that are in wheelchairs and pushing them in the hallway, which made the other residents upset. - 2/11/25, R22 was confrontational with a male resident he had a previous altercation with. Staff intervened before anything could occur. - 2/15/25, R22 was wandering and difficult to redirect. R22 continued to get into other male residents faces as if trying to fight them, and getting into yelling matches. Gets mad at staff, yells and shakes fist with any attempt to redirect him. - 2/16/25, R22 approached another resident and took his cane. Became agitated when staff attempted to get the cane back. R22 approached another male resident who was on the phone. R22 hovered over the resident hollering at him for sitting in the chair. The unidentified resident became very upset and verbalized he did not want R22 near him. R22 became more agitated with staff attempts to redirect him. Eventually R22 moved away, however, returned again two minutes later with the same outcomes. - 2/20/25, R22 wandered the halls and entered other resident rooms. R22 was near the entrance door when another resident entered from smoking outside and began to shout at R22. R22 became upset and shook his fist at the other	F 744		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 744	Continued From page 54 resident. R22 was redirected away without incident. - 2/21/25, after a confrontation with another resident, R22 became very agitated, kept showing his fist and stated "She is nuts. I'm going to show her. I'm going to knock her right out". - 2/22/25, R22 woke at 1:30 a.m. and was wandering into other resident rooms. - 2/22/25, R22 was pacing the halls and going in and out of other resident rooms, which was upsetting the other residents who were still in bed. - 2/22/25, R22 had a pocket full of another residents markers that he had picked up from the activity room. The resident followed R22 to get the markers back until staff redirected the residents away from each other. - 2/23/24, R22 pushed a resident that was in her wheelchair and when asked to stop would not listen and continued to push the resident down the hall. R22's medical record lacked a comprehensive behavior assessment to address types of behaviors, triggers, a review of interventions that worked or did not along with resident to resident incidents inlcuding person centered specific interventions to limit the behaviors. During interview on 2/25/25, nursing assistant (NA)-F stated when R22 appears agitated the staff walk with him and give him one to one. R22 would shake his fist at other residents and when staff see him doing that they separate them. They usually could redirect R22 away with diversional conversation. NA-F was not aware if R22 had actually hit another resident. A joint interview was conducted with registered	F 744		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 744	Continued From page 55 nurse (RN)-B, RN-C and the director of nursing (DON) on 2/25/25, at 4:49 p.m. RN-B stated R22 had not been feeling well or eating well that week and so had remained in his room. R22 had threatened other residents by shaking his fist at them and getting in their personal space, but she thought that was improved. The DON stated since the facility had gotten his psychotropic medications adjusted R22 has shown improved behavior. Now when approached by staff when he is angry and shaking his fist, he will say I do not want to hit you, or when he sees R28, who frequently hollers at him, he will say I need to stay away from that one. R22 was showing more awareness of his behaviors. RN-C felt resident to resident incidents were decreasing and when the other residents ignored R22, he walked right by, but some of the residents were super vigilant towards R22 and escalated the behaviors. RN-C stated some of the residents were over anxious because of past behavioral incidents and scared because they were vulnerable. R22 had a friend visit him and when the friend saw R22 had a male roommate the friend approached staff and reported R22 does not really get along with roommates, and so we moved the roommate to another room as a precaution. During interview on 2/26/25, licensed practical nurse (LPN)-A stated R22 could be a handful. R22 did not know boundaries and would get into others faces and the other residents, especially the male residents, did not like that. The staff kept an eye on him when he was out of his room and provide one to one supervision when agitated. LPN-A did not think other residents were afraid of R22, just irritated as he gets right in your face and does not have any boundaries.	F 744		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 744	Continued From page 56 During telephone interview on 2/26/25, at 12:09 p.m. RN-D stated she had worked when R22 had pushed R down the hall in her wheelchair.R22 liked to push things. When R22 was restless or agitated RN-D tried to talk with him and talk him down. RN-D thought R22 listened to her as it was in the way he was approached. R22 did not respond well to loud voices. RN-D felt R22 really needed one to one supervision and should always have someone with him. There was just not enough staff to provide one to one to him all the time. R22 will make comments he is going to punch a resident or hit them and would even make comments like I am going to kill you. His words are jumbled up though and the other residents frequently would not understand him and just tell him to get away from them. During telephone interview on 2/27/25, at 2:48 p.m. the medical director (MD)-D stated he had not been notified of any of R22's resident to resident interactions. He had gotten calls to refill R22's PRN lorazepam when the primary physician was not available. He would not expect the facility to call him with resident behaviors even if other residents were involved or affected. MD-D expected the facility to call the primary physician and the primary could adjust the resident's medications or send him to the emergency room to be evaluated. The only time MD-D would expect a call from the facility is if the primary physician could not be reached. The facility policy Dementia Care with revision date 4/5/16, identified a comprehensive assessment of each resident would be completed on admission. The assessment would include usual cognitive patterns, mood and any behavioral distress associated with dementia the	F 744		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 744	Continued From page 57 resident has had in the past, what behaviors have occurred and their possible underlying causes, and approaches that calmed the resident once they became distressed. If a resident appeared to be distressed, staff would describe the specific experience and implement non-pharmacological approaches according to the identified cause. Staff would evaluate whether the cognitive patterns, mood or behaviors present a risk to the resident or others and in collaboration with the practitioner, identify risk and underlying causes for the resident's distress related behaviors. If the resident had behaviors that appeared to be distress- related, the care plan would reflect an individualized approach with a description of potential distress triggers and nonpharmacological approaches to implement when distress is expressed or indicated.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 58 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist recommendations were addressed and acted upon and documented in the medical record for 3 of 5 residents (R11, R22, R36) reviewed for unnecessary medication use. Findings include: R11: R11's admission Minimum Data Set (MDS) dated 11/21/24, identified R11 had severe cognitive impairment and diagnoses included Alzheimer's disease and malignant neoplasm of rectal sigmoid junction.	F 756	1.Consulting Pharmacist recommendations will be reviewed by DON and/or designee for R11, R22, and R36 to ensure they have been addressed. 2.All residents have the potential to be affected by this deficient practice. 3.Consulting Pharmacist recommendations will be reviewed by Consultant Pharmacist and DON for all residents for the past 6 months to ensure they have been followed up on. All recommendations that lack follow-up will be faxed to the Primary Provider by the DON and/or designee to address. 4.The DON created a Consultant Pharmacist Services policy on 3/21/25. This policy includes process for	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 59 R11's Order Summary Report dated 2/17/25, identified R11's current medication regimen with their corresponding start dates. This included an order for quetiapine (an antipsychotic) 25 mg one tablet at bedtime related to dementia with other behavioral disturbances with order date 11/26/24. R11's completed Consultant Pharmacist's Medication Review, dated December 2024, identified R11's medication regimen was reviewed and an irregularity was listed involving R11's medication quetiapine with related to the indication for the medication was listed as dementia with anxiety and no behavioral disturbance. The suggested course of action identified it was prudent to verify the accuracy for low dose quetiapine as these sometimes were not appropriate to continue. Please verify the indication accuracy. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it and providing a rational and the resident was on the lowest effective does. The review was requested for "... ASAP [as soon as possible] but no later than 30 days." R11's medical record lacked evidence the consulting pharmacist's recommendation on R11's quetiapine dose irregularity had been forwarded, reviewed and/or acted upon by the physician. When interviewed on 2/27/25, at 2:12 p.m. the director of nursing (DON) stated a dementia diagnosis was not enough to prescribe quetiapine and she planned to speak with the provider regarding the issue. During telephone interview on 2/27/25, at 12:54	F 756	medication regimen review, storage and handling of reviews, and that the DON and Medical Director are notified of all recommendations per CMS regulation. 5.Administrator educated DON on the Consulting Pharmacist Reports and recommended handling and storage procedures on 03/19/25. This included: a) The consultant pharmacist reviews each resident at least monthly, or more frequently under certain conditions, following CMS regulations. b) The consultant pharmacist documents either that no irregularity was identified or the nature of any identified irregularities and provides these documents to the director of nursing. c) The consultant pharmacist will identify on the medication regimen review document the timeframe that the irregularity needs to be addressed within. d) The director of nursing then reviews all recommendations with the resident's attending provider and notifies the Medical Director of any irregularities. e) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. Resident-specific recommendations that have been addressed/documented on by the provider and/or nursing are recorded in the resident's active record, which is located in the resident's active chart or electronic record, and placed in the	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 60 p.m. the consulting pharmacist (CP)-E stated she made a recommendation in December dementia was not an appropriate diagnosis to prescribe quetiapine. When CP-E had spoken with the DON she had been told everything was addressed by the physician in January, then it was discovered it had not been. During telephone interview on 2/27/25, at 3:29 p.m. R11's primary provider (DR)-A stated when the medication is ordered, a diagnosis pops up and he had chosen it. DR-A was not aware of the regulations and nobody had brought the issue up to him when he conducting rounds at the facility. DR-A did the medical rounds and the mental health practioner nurse practioner (NP)-F did the mental health rounds. NP-F would be more aware of the regulations regarding those medications. On 2/27/25, at 4:01 p.m. NP-F was called with a request for a return call, however, none was received. R22: R22's admission MDS dated 1/17/25, identified R22 had severe cognitive impairment and diagnoses included neurocognitive disorder with Lewy bodies dementia. R22's Order Summar Report dated 1/12/25, identified current medication regimen with their corresponding start dates. Including the following as needed (PRN) orders: -quetiapine 25 milligrams (mg) by mouth (po) every 24 hours as needed for anxiety/agitation. Start Date of 1/10/25, with no end date ordered. R22's Order Summary Report dated 2/3/25,	F 756	Consulting Pharmacy Binder. f)The Director of Nursing will monitor to ensure all recommendations are completed. 6.RN Case Managers will be educated by the DON on the Consultant Pharmacist Servies policy. 7.QAPI team will check the binder monthly to ensure all Consulting Pharmacist Reviews are present and signed by DON and Residents Primary Provider beginning the week of 3/24/25. 8.The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 61 identified current medication regimen with their corresponding start dates. Including the following as needed PRN orders: -haloperidol injection 5mg/milliliter (ml) inject 0.5 ml intramuscularly (IM) every hour PRN for agitation/aggressive behaviors related to neurocognitive disorder with lewy bodies. Start date of 1/22/25, with no end date ordered. -lorazepam injection 2 mg/ml inject 0.5 ml IM as needed for agitation. May have up to two doses daily after 30 minute interval. Start date of 1/22/25, with no end date ordered. -lorazepam 1 mg by mouth (po) every four hours PRN for agitation and aggression. Start date 1/19/25, with no end date ordered. -olanzepine 5 mg tablet, give one tablet every 12 hours PRN for agitation related to neurocognitive disorder with lewy bodies. Start date of 1/22/25, with no end date ordered. R22's completed Consultant Pharmacist's Medication Review, dated January 2025, identified R22's medication regimen was reviewed and an irregularity was identified involving R22's PRN medication quetiapine with comment that PRN antipsychotic medications were limited to a 14 day duration based on CMS guidelines. When prescribing PRN antipsychotic's the medical record would include indication/clinical need, dose and frequency of use. If the treatment was to be extended after the initial treatment duration had ended, the resident must be re-evaluated and a new order provided each time. The suggested course of action listed was to re-evaluate the clinical appropriateness of the current therapy. Add a 14 day stop date to the antipsychotic and if the treatment was to be continued, to perform a clinical evaluation/examination of the resident and	F 756		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 62 provide a new order as specified above after the initial 14 days. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days." R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen had been reviewed and irregularity was listed involving R22's PRN medication haloperidol injections with comment that R22 was admitting with an order for a PRN antipsychotic medication, however, there was no stop date/duration indicated on the order. Per CMS guidelines, PRN antipsychotic orders must be limited to a 14 days. Additionally, guidelines require a face to face provider evaluation, documentation of clinical rationale and a new order with a 14 day stop date to continue the PRN antipsychotic. The suggested course of action listed was to ensure all new PRN antipsychotic orders were accompanied by 14 day stop dates. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days." R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen was reviewed and an irregularity was identified involving R22's PRN medication lorazepam tablet with comment PRN psychotropic such as lorazepam were limited to a 14 day duration based on updated CMS guidance and rules unless the prescriber chose to extend treatment by providing clinical rationale and documentation	F 756		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 63 of intended duration. When prescribing PRN psychotropics, the medical record should include the indication/clinical need, dose and frequency of use. If treatment was to be extended after the pintail treatment duration had ended, the resident must be re-evaluated and a new order provided. The suggested course of action listed was to reevaluate appropriateness of the continued therapy. If continued to add an appropriate stop date for the psychotropic medication and document duration of threaten and clinical evaluation/rationale of the resident. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days." R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen was reviewed and an irregularity was identified involving R22's PRN medication lorazepam injection with comment PRN psychotropics such as lorazepam were limited to a 14 day duration based on updated CMS guidance and rules unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. When prescribing PRN psychotropics, the medical record should include the indication/clinical need, dose and frequency of use. If treatment was to be extended after the pintail treatment duration had ended, the resident must be re-evaluated and a new order provided. The suggested course of action listed was to reevaluate appropriateness of the continued therapy. If continued to add an appropriate stop date for the psychotropic medication and document duration of threaten and clinical	F 756		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 64 evaluation/rationale of the resident. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days." R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen had been reviewed and irregularity was listed involving R22's PRN medication olanzapine with comment that R22 was admitted with an order for a PRN antipsychotic medication, however, there was no stop date/duration indicated on the order. Per CMS guidelines, PRN antipsychotic orders must be limited to a 14 days. Additionally, guidelines require a face to face provider evaluation, documentation of clinical rationale and a new order with a 14 day stop date to continue the PRN antipsychotic. The suggested course of action listed was to ensure all new PRN antipsychotic orders were accompanied by 14 day stop dates. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days." R22's Febuary Medication Administration Record (MAR) was reviewed 2/1/25 through 2/24/25 and identified R22 received PRN lorazepam daily and 12 of the 24 days had received the medication two to four times per day. R22 received the PRN olanzapine 14 times during that period. R22's medical record was reviewed and lacked evidence the consulting pharmacist's recommendation on R22's identified medication	F 756		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 65 irregularities had been forwarded, reviewed and/or acted upon by the physician. During telephone interview on 2/27/25, at 12:54 p.m. the consulting pharmacist (CP)-E stated she had made a recommendation in January to make sure the provider completed a face to face evaluation and then every 14 days. When CP-E spoke with the DON she was told everything was addressed in January but during her review in February CP-E had to reissue her recommendations. That was when the DON discovered the recommendations had not been addressed by the provider. CP-E would have expected the provider to follow up on her recommendations within 7 days and they were not. When interviewed on 2/27/25, at 2:12 p.m. the DON stated she was aware antipsychotic and psychotropic medications needed to be evaluated within 14 days with a duration stop date and PRN antipsychotic medications needed to have a face to face provider evaluation.The DON was not sure what the facility's process was for obtaining the information needed to meet the requirement. The DON had given the pharmacist recommendations to another nurse to address with the physician she was not sure why they were not addressed. The DON stated she needed to do a better job following up on the pharmacy recommendation with her nurses. During telephone interview on 2/27/25, at 3:29 p.m. R22's primary provider (DR)-A stated he was not aware a face to face evaluation was required every 14 days when prescribing PRN antipsychotic medications. He did know R22 was very aggressive and had attacked staff. MD-A	F 756		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 66 saw R22 two times since his admission and the nurses never mentioned the regulation. MD-A did the medical rounds and the mental health practioner nurse practioner (NP)-F did the mental health rounds. NP-F would be more aware of the regulations regarding those medications. On 2/27/25, at 4:01 p.m. NP-F was called with a request for a return call, however, none was received. R36: R36's admission MDS dated 12/11/24, identified R36 had intact cognition and diagnoses included general anxiety disorder, depression, chronic pain and bipolar disorder. R36's Order Summary Report dated 2/27/27, included the current medication regimen with their corresponding start dates. This included orders for clonazepam 1 mg in the morning and 0.5 mg at bedtime, diazepam 5 mg every 24 hours as needed for anxiety, hydrocodone-acetaminophen 7.5-325 mg every 8 hours as needed and hydrocodone-acetaminophen 7.5-325 mg every 8 hours for pain. R36's completed Consultant Pharmacist's Medication Review, dated December 2024, identified R36's medication regimen was reviewed and an irregularity was identified involving R36's medication diazepam with comment since the medication was used for a psychological condition and due to updated CMS regulations, the PRN medication had to be re-evaluated within the first 14 days of starting. If the medication was to be continued a re-evaluation date was needed. The suggested	F 756		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 67 course of action listed was to add a re-evaluation date to re-assess, i.e., continue for 60 days then re-evaluate, etc. R36 was also taking another scheduled benzodiazepine, clonazepam two times per day. There was a potential for addictive effects and increased adverse reactions. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 30 days." R36's completed Consultant Pharmacist's Medication Review, dated January 2024, identified R36's medication regimen was reviewed and an irregularity was lidentified involving R36's medication hydrocodone/acetaminophen with comment R36 was at increase risk for CNS/respiratory depression due to the combined use of a benzodiazepine and an opioid analgesic. Hydrocodone/acetaminophen and clonazepam. The suggested course of action listed recommended re-assessing the use of the combination of medications. Please provide clinical rationale, for documentation purposes, the the current benefits outweigh the risks. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 30 days." R36's medical record lacked evidence the consulting pharmacist's recommendation on R36's benzodiazepam and opioid medications had been forwarded, reviewed and/or acted upon by the physician.	F 756		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 756	Continued From page 68 A policy was not received for pharmacy reviews.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 69 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure use of an as-needed psychotropic medication was limited to a 14-day period and/or re-evaluated by the provider to ensure ongoing need and efficacy of the medications for 2 of 5 residents (R18,R22) reviewed for unnecessary medication use. In addition, the facility failed to complete comprehensive assessment and ongoing monitoring of behaviors for an administered antipsychotic medication to ensure efficacy of the medication for 1 of 5 residents (R11) reviewed for unnecessary medication use. Findings include: R18: R18's significant change Minimum Data Set (MDS) dated 1/6/25, identified R18 had a severe cognitive impairment and diagnoses that included Alzheimer's disease and dementia. R18 did not exhibit behaviors during the assessment period. R18's undated care plan, identified R18 used	F 758	1. DON notified R18 primary provider on 3/21/25 that R18 PRN lorazepam needs to be reviewed. R18 provider scheduled to see resident on 3/26/25 to review use of PRN lorazepam, including documentation of rationale for continuation of use longer than 14 days, and a specific duration for use. 2. DON notified R22 primary provider on 3/21/25 that a face-to-face needs to be completed with documentation for rationale of continuing the use of R18s PRN quetiapine. R22 provider scheduled to see resident on 3/26/25. 3. RN Case Manager and/or Social Services Director will complete a behavior assessment for R18, R22, and R11 and will update the care plan related to behaviors. 4. RN Case Manager and/or designee will schedule a target behavior order for R18, R22, and R11, for the licensed nurse to monitor for those target behaviors and document if exhibiting any target behaviors every shift.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 70 anti-anxiety medications (lorazepam) related to recent changes in health status. Interventions included: - Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. - Make referrals for me as needed - Monitor me for safety. I am taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. - Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations - Monitor/record occurrence of for target behavior symptom, inappropriate response to verbal communication, violence/aggression towards staff/daughter and document per facility protocol. - My non-pharmacological interventions include: 1: 1, Distraction/redirection, family visits. - Observe for changes in my behavior and update provider R18's physician order dated 1/16/25, identified lorazepam tablet 0.5 milligram (MG). Give one tablet by mouth every two hours as needed for anxiety or agitation. R18's electronic medication administration record (EMAR) dated January 2025, identified R18 received lorazepam on 1/29/25.	F 758	5. IDT will monitor R18, R22, and R11 behaviors and the effectiveness of their psychotropic medication use quarterly during QAPI, and as needed. 6. R18, R22, and R11 primary physician will monitor/review use of psychotropic medications on their regulatory visits and as requested by the care center or consultant pharmacist ongoing. 7. All residents with psychotropic medication orders have the potential to be affected by this deficient practice. 8. DON reviewed the Psychotropic Medications Policy on 03/17/25 with no changes needed. 9. RN Case Manager will review all psychotropic medication orders to ensure they have a valid diagnosis for the use of the medication. 10. DON and/or designee will conduct a review of all PRN antipsychotic medications to ensure there is a 14 day stop date, and all PRN psychotropic orders (excluding antipsychotics) have a 14 day stop date or a specific duration indicated with provider documentation on the rationale for extending beyond 14 days. 11. DON and/or designee will educate all providers delivering care to the residents of the Psychotropic Medications Policy including the requirement of appropriate diagnosis for use of psychotropic medications, documenting rationale for psychotropic medication increases, the need for a face to face visit every 14 days to evaluate the continued use of PRN antipsychotic medications, and all PRN psychotropic orders (excluding	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 71 R18's EMAR dated February 2025, Jan EMAR identified R18 received lorazepam on 2/11/25 and 2/21/25. R18's medical record failed to identify if a a face-to-face provider evaluation for continued use of a as needed (PRN) psychotropic medication was completed. R18's nursing progress notes identified the following: - 1/16/25 at 2:27 p.m., R18 was slightly declining for the past 48 hours. Concerns were discussed with family. Orders were obtained from the medical director (MD) to ensure R18 remained comfortable and had no anxiety/anxiousness. Lorazepam 0.5mg every 2 hours as needed and morphine sulfate 20mg/milliliter (mL), give 0.125mL every 2 hours as needed for severe pain/discomfort, and oxygen to maintain sats above 90% or for comfort. These medications should only be utilized if/when R18 was no longer safe to obtain oral pain medications. - 1/29/25 at 6:10 p.m., R18 was in the dining room sitting at her daughter's table and started yelling "help me help me, I want to lay down". When approached, R18 started yelling that she needed to go to bed. Staff took R18 to her room and got her into her bed. R18 was not in her bed 10 minutes, and R18 began yelling that she wanted to get up. Staff got her up and then R18 started to say she wanted to lay down again. Staff would tell her that she needed to stay up for a while and that they could not keep laying her down and getting her back up. Staff was administered 0.5mg Ativan at 6:01 p.m. for anxiety. R18 was saying that her legs hurt, she did get her pain medication as scheduled at 5:50 p.m. R18 was sitting in the dining room and kept	F 758	antipsychotics) have a 14 day stop date or a specific duration indicated with provider documentation on the rationale for extending beyond 14 days. 12. DON and/or designee will complete audits to ensure that PRN antipsychotic orders have a 14-day stop date and all PRN psychotropic orders (excluding antipsychotics) have a 14 day stop date or a specific duration indicated with provider documentation on rationale for extending beyond 14 days 3x/week x 2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning the week of 3/24/25.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 72 asking staff to lay her back down. - 2/11/25 at 3:58 p.m., R18 was lying in bed and started hollering "help me"," help me"!! When staff arrived, R18 was flailing her arms and legs around and starting to dry heave. Staff was unable to get R18 to calm down, staff administered 0.5mg Ativan at 3:46 p.m., a warm blanket and sat by her bedside until R18 calmed down and fell asleep. - 2/21/25 at 12:46 a.m., R18 was yelling out non-stop. R18 insisted that she was laying on top of a car and the guys have to get her off. Staff spent 1:1, changed her brief, gave fluids and offered a snack. Staff was unable to redirect/reorient her. She declined snack, took in fluids but continued to yell out. R18 was anxious and teary, very agitated. As needed lorazepam 0.5 mg was given. Staff continued to reassure R18 that everything was okay. During an interview on 2/27/25 at 12:55 p.m., registered nurse (RN)-F stated she recently learned an as needed antipsychotic should be re-evaluated with a face-to-face provider visit every two weeks. I just learned that yesterday. RN-F stated R18's medical record lacked information identifying a face-to-face provider evaluation was completed. During a phone interview on 2/27/25 at 3:29 p.m., R18's physician (DR)-A stated he was unaware of the requirement to perform a face-to-face re-evaluation of antipsychotic PRN medications every 14 days and nursing did not inform him.	F 758		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 73	F 758		

R11:

R11's admission MDS dated 11/21/24, identified R11 had severe cognitive impairment and required moderate assistance with dressing, bathing, and toileting. R11 was identified to have wandering one to three times during the assessment period and did not exhibit physical or verbal behaviors toward others. R11's diagnoses included malignant neoplasm of the rectal sigmoid junction and thrombocytopenia.

R11's care plan with revision date 12/24/24, identified R11 was at risk for elopement and wandering. Interventions included to provide a wander guard and structured activities such as toileting, walking, and reorientation strategies such as signs, pictures, and memory boxes. Use of psychotropic medications related to behavior management was also identified. Staff were instructed to administer medications as ordered, monitor for side effects, discuss with physician regarding ongoing need and indicated R11 was on a behavior management program, however, lacked documentation of what behaviors were exhibited and/or what the behavior management program entailed. The care plan further identified R11 at risk for insomnia with interventions to

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 74 administer medications as ordered, maintain a consistent routine to retire and wake up and discourage daytime naps. R11's Order Summary Report dated 2/17/25, identified an order for quetiapine 25 mg one tablet at bedtime related to dementia with other behavioral disturbances with order date 11/26/24, gabapentin 250 mg/5ml give 1 ml three times per day related to dementia with other behavioral disturbances with order date 1/22/25, and escitalopram 2.5 mg every morning related to dementia with other behavioral disturbances with order date 12/18/24. Staff were directed to monitor for side effects related to the psychotropic medications. Target behaviors with order date 11/29/24, listed depression with non-pharmalogical approaches of one to one, distraction, calm approach and offer food/drink every shift. Staff were to record if behaviors had been observed or not observed. R11's Order Summary Report dated 2/26/25, identified R11's gabapentin was increased from 1 ml three times per day to 1.5 ml three times per day with start date 2/24/25. The medical record lacked an assessment to support the increase in gabapentin. R11's MAR for February 2025, identified the medication quetiapine, gabapentin and escitalopram was administered every day 2/1/24 through 2/26/25, as ordered. Target behaviors were not monitored on the February 2025, MAR. On 2/25/25, at 11:20 a.m. R11 was observed standing with walker in his room doorway, fully dressed in preparation to go to the dining area for lunch. When staff attempted to redirect R11 back	F 758		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 75	F 758		

into room, R11 stated no he did not want to eat in his room. R11 was assisted to put on a face mask and assisted to the dining area. R11 remained seated alone at the dining room table, removing his mask only to eat and then returned to his room.

On 2/26/25, at 11:36 a.m. R11 was observed seated in a recliner in his room. R11 was seated quietly in his room. There was no television in room and/or magazines visible nearby. R11 watched as staff and residents passed by the room and occasionally would holler out a greeting and/or smile and wave.

A joint interview was conducted on 2/27/25, at 9:13 a.m. with nursing assistant (NA)-A and NA-H. NA-A stated she was not aware R11 had any behaviors. R11 could sometimes act a little grumpy or anxious but liked to joke around and would soon come out of it. R11 was a nice man but would at times get anxious if he had nothing to do. R11 always seemed to need something to do but once you found something to occupy him, he was fine. NA-H stated R11 was very nice and liked to read the paper in the dining area and people watch. R11 enjoyed visiting with others and staff frequently sat down with him to visit and he would laugh and joke with them. Never resistive or combative with cares or others.

R11's progress notes, dated 1/28/25 to 2/24/25, were reviewed. A progress note dated 2/18/25, identified R11's mood was pleasant with no unwanted behaviors witnessed and R11 slept through the night. No behavioral incidents were recorded in the 28-day period reviewed.

R11's medical record lacked evidence what

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 76	F 758		

symptoms or specific behaviors were being tracked or monitored to ensure the efficacy of the ordered quetiapine and gabapentin and support the use of the medications.

During interview on 2/27/25, at 9:33 a.m. registered nurse (RN)-B stated R11 had dementia and experienced a lot of anxiety, but she never witnessed aggressive behaviors. The gabapentin was increased on 2/24/25, for R11's own comfort to see if they could make him feel better. R11 would wander and get very anxious and make comments that he did not know why he was here or what he should be doing. R11 seemed more comfortable now and less episodes of those behaviors happening. RN-B did not do rounds with the mental health provider NP-F and so was not sure what was discussed when NP-F increased R11's medication. R11's anxiety was not on the care plan, and it should have been. It would be important to list the type of behavior R11 exhibited and the interventions so staff could utilize them before medication to decrease R11's symptoms of loneliness and depression.

During telephone interview on 2/27/25, at 12:54 p.m. the consultant pharmacist (CP)-E stated R11 received quetiapine at bedtime for dementia and that was not an appropriate diagnosis for the medication unless there was evidence the behaviors could harm self or others. There were usually targeted behaviors and non pharmalogical interventions in the care plan related to the use of antipsychotic medications and she had noticed R11's care plan did not address behaviors. CP-E had also noted NP-F had increased R11's gabapentin in January and there was no rationale for the increase in R11's medical record. CP-E reviewed all the progress notes for behaviors as

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 77 well and could not find rationale for the medication increase documented. During interview on 2/27/25, at 2:12 p.m. the DON stated she would expect anxiety and related behaviors to have been documented on R11's plan of care. She knew R11 had a lot of anxiety, and she would have expected some behavioral incidents to have been documented in his progress notes to justify the initiation and two increased doses of gabapentin ordered and/or whether the medication was successful or not. Dementia alone was not enough of a reason to prescribe quetiapine or gabapentin, and the DON needed to speak with the provider regarding the issue. During telephone interview on 2/27/25, at 3:29 a.m. with R22's primary physician (DR)-A stated he was not sure who had first prescribed quetiapine for R11, however, he thought he had done the admission orders. The diagnoses just popped up on the chart and he picked the most appropriate diagnosis. DR-A was not aware of all the regulations and the issues had not been brought up to him when he conducted rounds at the facility. R11 was seen by a mental health provider NP-F and she would be more aware of all the regulations surrounding those type of medications. On 2/27/25, at 4:01 p.m. NP-F was called with a request for a return call; however, none was received. The facility policy Psychotropic Medications dated 8/20/24, identified the facility would have the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of	F 758		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 758	Continued From page 78 environmental, medical, behavioral interventions and psychopharmacological medications could be utilized to meet the needs of the individual resident. Primary providers would order psychotropic medication only for the treatment of specific medical and/or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by non-pharmacological approaches. The provider would document rationale and diagnosis for use and identify Target Behavior symptoms for the reason the medication was being utilized. PRN psychotropic medications ordered would be limited to 14 days. The prescribing practitioner would evaluate and document the medications necessity, benefits, and improvement (expressions, indications of distress). If the physician deemed it appropriate to extend beyond the 14-day limit, supporting rationale must be documented. The facility staff would monitor and document for the presence of target behaviors daily, charting by exception (i.e., charting only when the behaviors are present), noting any adverse effects, review usage of the medications with the physician and the IDT on a quarterly basis to determine the continued presence of target behaviors and/or presence of any adverse effects, implement non-pharmacological interventions for target behavior(s), document results, and add to care plan, and utilize PRN psychotropic medication, following provider order, if non-pharmacological intervention(s) are unsuccessful.	F 758		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/11/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 79 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 80 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement transmission-based precautions (TBP) for respiratory symptoms until confirmatory respiratory test results were obtained for 6 of 38 residents (R34, R31, R11,R22, R36, R32), failed to initiate droplet precautions for 1 of 6 residents (R31) known to test positive for influenza A, failed to implement strategies to mitigate the risk of an influenza outbreak, including initiating active surveillance of residents for signs and symptoms of influenza A, isolation of residents presenting	F 880	Director of Nursing completed an audit on 2/25/25 for R34, R31, R11, R22, R36, and R32 and all were placed on droplet precautions, had appropriate droplet precaution signage on their door, PPE cart supplied, and placement of hamper/linen cart and waste container. R34, R31, R11, R22, R36, and R32 remained on droplet precautions following CDC guidelines. The Infection Prevention and Control	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 81 with symptoms of influenza A, and post signage at the facility entrances to notify visitors of active illness in the facility. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility when 8 of 38 residents (R31, R11 , R36, R32, R38, R7, R35, R3) contracted influenza A. This resulted in an immediate jeopardy (IJ) which placed all 38 residents at a high likelihood for serious illness and/or death by contracting a communicable disease, including but not limited to influenza A. In addition, the facility failed to track and trend all resident actual/potential infection on the monthly tracking form to effectively identify symptoms and reduce the spread of infection with a potential to affect all 38 residents residing in the facility. The IJ began on 2/13/25, when R34 exhibited symptoms of respiratory illness, was not isolated or placed on TBP when symptoms were exhibited, and subsequently tested positive for influenza A on 2/14/25, and failed to implement interventions to reduce the spread of influenza A which resulted in eight other residents contracting influenza A. The director of nursing (DON) was notified of the IJ on 2/24/25, at 9:27 p.m. The IJ was removed on 2/26/24, at 10:26 a.m. when the facility implemented actions to reduce/prevent the spread of illness. However, noncompliance remained at the lower scope and severity, F widespread, which indicated no actual harm with potential for more than minimal harm that was not IJ. Findings include: INFLUENZA A OUTBREAK:	F 880	Nurse completed a care center wide audit on 2/25/25 to identify any other current residents with respiratory signs and symptoms and/or positive for Influenza A. R38, R7, R35, and R3 were also placed on droplet precautions, had appropriate droplet precaution signage on their door, PPE cart supplied, and placement of hamper/linen cart and waste container. R38, R7, R35, and R3 remained on droplet precautions following CDC guidelines. R34, R31, R11, R22, R36, R32, R38, R7, R35, and R3 are currently asymptomatic no longer on droplet precautions. The Transmission-Based Precautions policy was reviewed and revised on by the Quality Consultant on 2/25/25. The policy outlines procedure for when a resident is exhibiting symptoms of a potentially communicable infection, procedure for implementing droplet precautions, and posting signage notifying visitors of current illness/infection outbreak. All nursing staff began receiving education on 2/25/25 by the Director of Nursing and/or designee on the Transmission Based Precautions Policy related to procedures for implementing transmission based precautions for a resident who is suspected of, or identified as, having a communicable infectious disease and procedure for droplet precautions. Nursing staff received education starting on 2/25/25 by the Director of Nursing and/or designee regarding residents that are rooming with influenza A positive	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 82 The Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities from the Centers of Disease Control (CDC) dated 9/17/24, identified influenza can be introduced into a long-term care facility by newly admitted residents, healthcare personnel, and visitors. Spread of influenza can occur between and among residents, healthcare personnel and visitors. Residents of long-term care facilities can experience severe and fatal illness during influenza outbreaks. If one laboratory-confirmed influenza positive case was identified along with other cases of acute respiratory illness in a unit of a long-term care facility, an influenza outbreak might be occurring. Active surveillance for additional cases should be implemented as soon as possible once one case of laboratory-confirmed influenza is identified in a facility. When 2 cases of laboratory-confirmed influenza were identified within 72 hours of each other in residents on the same unit, outbreak control measures should be implemented as soon as possible. Droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Droplet Precautions should be implemented for residents with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a resident is in a healthcare facility. The CDC guidance for Flu and People 65 Years and Older dated 9/5/24, identified people 65 years and older are at higher risk of developing serious flu complications compared with young, healthy adults. This increased risk is due in part to changes in immune defenses with increasing	F 880	residents, including R14, will have the curtain drawn at all times, staff caring for those residents will wear PPE for droplet precautions and if those residents chose to leave their room they will wear a mask and socially distance, and that they should be offered to move to an empty room if there is availability. DON and IPCO nurse reviewed availability of rooms on 2/25/25 to determine if any residents who were rooming with a resident who had signs and symptoms of Influenza A or positive for Influenza A, including R14, could be offered to move to a different room, but there were no other appropriate rooms available. R14 was encouraged to stay in their room, but if they choose to leave their room, they would wear a mask and social distance. All care center staff received education starting on 2/25/25 by the Director of Nursing and/or designee on providing a resident a mask who is on droplet precautions and redirecting them back to their room if observed out of their room, including R22 and R36. The Infection Prevention and Control Nurse placed signage on all entrances on 2/24/25 notifying visitors of current active influenza outbreak. All licensed nurses received education starting on 2/25/25 by the Director of Nursing and/or designee on communicating with the nursing assistance when a resident is placed on droplet precautions.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 83 age. While flu seasons vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease. In recent years, for example, it ' s estimated that between 70 percent and 85 percent of seasonal flu-related deaths have occurred in people 65 years and older, and between 50 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people in this age group. On 2/24/25, at 11:30 a.m. surveyors entered the facility to conduct an annual recertification survey. No signs were posted to alert visitors an influenza outbreak was occurring in the facility. During the entrance conference 2/24/25, at 12:26 p.m. with the DON, the DON failed to identify there were any residents ill with respiratory illness or the facility may be experiencing an influenza outbreak. R34: R34's significant change Minimum Data Set (MDS) dated 2/11/25, identified R34 was 84 years of age and had moderately impaired cognition. R34 required maximum assistance with most activities of daily living (ADLs). R34 was vaccinated for influenza on 10/11/24. Diagnoses included Alzheimer's disease, acute kidney failure and encephalopathy. R34's progress notes identified on 2/12/25, R34 had developed a hoarse voice and dry cough and on 2/13/25, R31 had developed a low-grade temperature. A positive influenza test was identified on 2/14/25. Droplet precautions were put into place on 2/14/25.	F 880	The Infection Surveillance policy was reviewed and revised by the Quality Consultant on 2/25/25. All licensed nurses received education starting on 2/25/25 by the Infection Control Nurse and/or designee on the Infection Surveillance policy, including completing active surveillance of current residents for symptoms of Influenza A. Director of Nursing and Quality Consultant implemented an order for all residents who currently did not have any signs or symptoms of Influenza A on 2/25/25. This monitoring order stated: monitor for signs and symptoms of Influenza A every shift and document a progress note if no symptoms. If any respiratory signs or symptoms observed, place resident immediately on droplet precautions, and contact the resident Provider for orders to complete a respiratory panel. Notify the Charge Nurse and IPCO nurses as soon as possible. Document this in the residents progress notes. Complete a full set of vital signs each shift. This will continue until one week after the last laboratory-confirmed influenza case was identified. Infection Preventionist added R34, R31, R11, R22, R36, R32, R38, R7, R35, and R3 to the infection surveillance tracking logs in HealthConnex. All residents in the care center have potential to be affected by this deficient practice. Director of Nursing conducted a chart	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 84 R34's medical record failed to identify transmission-based precautions were implemented when R34 first presented with respiratory symptoms to prevent the spread of influenza A to other residents and staff. R31: R31's quarterly MDS dated 11/27/24, identified R31 was 68 years of age and had intact cognition. R31 required partial assistance with dressing and was dependent with toileting and bathing. R31 was vaccinated for influenza on 10/10/24. Diagnoses included congestive heart failure, and diabetes. R31's progress note on 2/23/25, identified R31 complained of not feeling well with body aches and wheezes noted in both lung fields. R31 was sent to the emergency room to be evaluated and returned on 2/24/25, at 2:20 a.m. with a positive influenza A test result. R31's medical record failed to identify droplet precautions were implemented when R34 returned from the hospital positive for influenza A, to prevent the spread of influenza A to other residents and staff. On 2/24/25, at 3:20 p.m. prior to the surveyor entering the room for screening nursing assistant (NA)-A stated R31 was on enhanced barrier precautions because R31 had a catheter in place. Staff were required to wear gown and gloves when providing close contact care. The personal protective equipment (PPE) was not required to visit with resident if not in close contact with resident. The surveyor proceeded to enter the room to complete the screening process for the survey.	F 880	review on 3/17/25 and there are currently no residents with respiratory signs/symptoms, positive for Influenza A, or on transmission-based precautions. The care center Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, with oversight from the Administrator will meet on 3/21/25 to conduct a root cause analysis to identify the problem(s) that resulted in the deficiency and develop intervention or corrective action plan to prevent recurrence. The Director of Nursing and Infection Preventionist reviewed the Transmission-Based Precautions policy on 3/21/25 and added donning/doffing of PPE following CDC guidelines and that source control measures will include providing masks to residents, visitors, and staff based on CDC guidelines. All staff will be educated on the Transmission-Based Precautions policy by the Director of Nursing and/or designee, including process for implementing transmission-based precautions and cohorting residents. The Quality Consultant educated the Infection Preventionist and Director of Nursing on the Infection Surveillance policy, including standard infection control practices, active surveillance, tracking and trending for a comprehensive infection control program on 3/21/25. The Director of Nursing and/or designee will complete	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 85 On 2/24/25, at 4:46 p.m. trained medication aide (TMA)-A was observed removing the enhanced barrier precaution sign on R31's door and placing a droplet precaution sign on the door. During interview on 2/24/25, at 4:46 p.m. TMA-A stated R31 only had enhanced barrier precautions sign on his door, which directed staff to gown and glove when providing personal care and did not require staff to mask. TMA-A had just put a new droplet precaution sign on R31's door that directed all persons to gown, glove, and mask prior to entering the room. TMA-A stated all the staff working that day were aware R31 had tested positive for influenza A since his return from the emergency room at 2:30 a.m., as it was reported during shift report that morning. The precautions sign had just not been changed. (the droplet precautions were placed 13 1/2 hours later) When interviewed on 2/24/25, at 4:59 p.m. the infection preventionist registered nurse (RN)-A stated R31's precautions should have been changed from enhanced barrier precautions to droplet precautions as soon as he returned from the emergency department. R11: R11's admission MDS dated 11/21/24, identified R11 was 87 years of age and had severe cognitive impairment. R11 required moderate assistance with dressing, bathing, and toileting. R11 was vaccinated for influenza prior to his admission to the facility. Diagnoses included malignant neoplasm of the rectal sigmoid junction and thrombocytopenia.	F 880	this education with the RN Case Managers and Charge Nurses. The Director of Nursing and Infection Preventionist reviewed and updated the Infection Surveillance policy on 3/21/25. Added all resident and employee infections will be documented on each shift by the nurse in charge and/or IPCO utilizing the care center designated infection surveillance tracking tool, transmission-based precautions will be implemented following the care center Transmission-Based Precautions policy, and any unexpected increases in infection must be reported to the Medical Director, and/or Public Health Department, and the state survey agency in order to obtain guidance/assistance for infection control concerns. Infection Preventionist will conduct a review of resident□s electronic health records starting on 2/1/25 to current to check that all resident signs and symptoms of infection and/or laboratory confirmed infection have been added to the infection surveillance tracking logs in HealthConnex. The Infection Preventionist and Director of Nursing will oversee that the following components are being implemented: a.Grouping of residents, or cohorting, should be done when possible to separate residents with an infectious disease (positive residents) form residents who are not affected. Plans to cohort should be carefully established in advance and	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 86 R11's progress note(s) identified on 2/24/25, R11 had required administration of acetaminophen 650 milligrams at 7:54 a.m. for a temperature of 101.4. On 2/24/25, at 1:13 p.m. a family member (FM)-A was observed sitting on R11's bed, in very close contact with R11, who was seated in his recliner in his room. FM-A stated R11 had a temperature that morning and had fallen getting out of bed as he was so weak. The facility had tested him for respiratory illness and were waiting on the results. FM-A was not wearing any PPE and there was no evidence transmission-based precautions were not implemented with close contact with R11. During observation on 2/24/25, at 1:20 p.m. two unidentified nursing assistants (NA) were seen entering R11's room to assist his roommate R14 to bed. R11 was seated in his recliner in the room, next to the fully open privacy curtain. The NAs drew the privacy curtain halfway across the room and assisted R14 to bed using a mechanical lift. The NAs re-opened the privacy curtain, used alcohol-based hand rub on their hands after completing the task and exited the room. Neither NA's put on personal protective equipment. There was no signage or PPE cart outside of R11's room to alert staff to the need for PPE when entering the room to prevent potential transmission to others. On 2/24/25, at 6:18 p.m. NA-C and NA-D were observed assisting R11 to the bathroom. NA-C, wearing mask and gloves, was kneeling in front of R11 who was seated on the toilet. NA-D was outside of the bathroom making the bed up. NA-D did not have gown or mask on. NA-D stated she remembered someone mentioning something	F 880	should be centered on implementation of infection control practices. Residents who are rooming with other residents on droplet precautions will be offered to move to an empty room if there is availability. When a private room is not available and cohorting is not achievable, use a curtain, keep always closed, and maintain at least three (3) feet of space between the infected resident and other residents and visitors. Staff caring for those residents will wear PPE for droplet precautions. b.Confine symptomatic residents to their rooms, if the must leave their room ensure the resident is wearing a mask. Encourage exposed roommates to their rooms, but if those residents chose to leave their room, they will wear a mask and socially distance. c.Use dedicated equipment for areas, as able. d.When a resident is placed on transmission-based precautions, clearly identify the type of precautions and the appropriate PPE to be used. Appropriate precaution signage or Stop See Nurse will be posted on the door before entering the room. While respecting the privacy of the resident color-coded signs and/or other measures will be utilized to alert staff of the implementation of precautions/notifications. Precaution information will be entered into resident□s electronic medical record (EMR). e.Make PPE readily available near the entrance to the resident□s room, have an identified donning/doffing area. Appropriate linen cart/hamper and waste	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 87 about wearing a mask but had forgotten. NA-D exited the room to read the precaution sign posted on R11's room door. The sign indicated R11 was on droplet precautions, and everyone must wear a mask and clean hands on entering and leaving the room. If contact with secretions were likely staff were directed to use gown, gloves and eye cover as well. NA-D stated she now realized she needed to wear a gown and mask. NA-D put on a gown and surgical mask and brought NA-C an isolation gown to put on. R11's progress note on 2/24/25, at 6:31 p.m. identified R11 tested positive for influenza A and was placed on droplet precautions. Appropriate signage and a PPE cart were placed outside of his door. R22: R22's admission MDS dated 1/17/25, identified R22 was 77 years of age and had severe cognitive impairment. R22 required supervision with ADL's. R22 had not been vaccinated for influenza virus. Diagnoses included neurocognitive disorder with Lewy bodies, and heart disease. During observation on 2/24/25, between 1:00 p.m., to 5:30 p.m. R22 was lethargic, lying halfway on his bed with both feet on the floor. R22 did not wake to eat lunch. At 2:00 PM. TMA-A and another unidentified staff member were attempting to arouse R22 to drink water. Neither staff were wearing any PPE. There were no isolation precautions or PPE cart noted in the room. R22's progress note(s) identified the following: - 2/24/25, at 11:09 a.m. a respiratory panel was	F 880	container, with appropriate liner, will be placed in or near (as appropriate) the resident□s room. f.Disposable or dedicated resident equipment will be used. If noncritical equipment is shared between residents, it will be cleaned and disinfected following manufacturer□s instructions with an EPA-registered disinfectant after use. g.Clean and disinfect on a more frequent schedule, those surfaces and equipment that are near the resident. Equipment that may be contaminated with pathogens, (e.g. bed rails, bedside commodes, over bed tables) and frequently touched surfaces in the resident care environment (e.g., doorknobs, surfaces in and surrounding toilets in residents□ rooms) shall be cleaned and disinfected on a more frequent schedule compared to that for minimal touch surfaces (e.g., horizontal surfaces in waiting rooms). h.For an illness/infection outbreak, post appropriate signage throughout the building and entrance(s) notifying visitors of the current illness/infection outbreak. i.Develop and implement an infection control program sign and symptom tracking tool to monitor all residents and staff for communicable, respiratory infection, according to CDC guidelines. j.Ensure the Charge Nurse and/or IPCO for each shift documents all resident and employee infections on the facility□s shared infection tracking log. Compliance and review of the infection control log will be completed by the Infection Preventionist daily when working. The data will be analyzed for possible	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 88 completed for cough, headache and body aches. - 2/24/25, at 2:02 p.m. identified R22 had been wandering throughout the shift, into other resident rooms and was difficult to redirect. - 2/24/25, at 7:20 p.m. identified R22 had not been feeling well that day and had complained of ear pain, neck pain and headache R22 had a temperature of 100.4 and oxygen saturation was 92%. A respiratory panel had been completed with results pending. R22 was sent to the emergency room for further evaluation. - 2/25/25, at 3:21 a.m. identified R22 had returned from the emergency room. R22's respiratory panel was negative, however, R22 continued to complain of neck pain, refused to eat his meals and remained in bed. R22's medical record failed to identify transmission-based precautions were implemented when R22 first presented with respiratory symptoms on 2/24/25, to prevent the spread of potential respiratory infections to other residents and staff. R36: R36's admission MDS 12/11/24, identified R36 was 71 years of age and had intact cognition. R36 was independent with his ADLs. R36 had been vaccinated for the influenza prior to his admission to the facility. Diagnoses included chronic obstructive pulmonary disease, irritable bowel syndrome, and abnormal weight loss. During interview on 2/24/25, at 2:51 p.m. R36 stated he was not feeling well and had not eaten much in two weeks. R36 reported he had fallen	F 880	trends/outbreaks. The Infection Preventionist will investigate any potential outbreaks and follow-up as appropriate. k.Review infection prevention tracking and trending. Any unexpected increases in infection must be reported to the Medical Director, and/or Public Health Department, and the state survey agency in order to obtain guidance/assistance for infection control concerns. All staff providing direct care to residents, and all staff entering resident□s rooms, whether it be for residents□ dietary needs or cleaning and maintenance services, will be educated on the Transmission-Based Precautions policy by the Director of Nursing and/or designee, including utilizing masks for source control masks, appropriate PPE use, and donning/doffing of PPE following CDC guidelines. All residents (to the degree possible/consistent with the resident□s capacity) and their representatives or visitors will be educated on the use of transmission-based precautions by the Director of Nursing and/or designee. Director of Nursing and/or designee will complete PPE donning/doffing demonstration competency with all staff providing direct care to residents, and all staff entering resident□s rooms, whether it be for residents□ dietary needs or cleaning and maintenance services. The Director of Nursing and/or designee 5x/week x 4 weeks, 3x/week x 4 weeks,	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 89 that morning because he was so weak. There were no isolation precautions, signage or PPE cart noted in the room. On 2/24/25, at 3:28 p.m. R36 was observed dressed in coat, hat and gloves, ambulating down the hallway. R36 stated he was going outside to smoke a cigarette. R36 stopped at the nurse's station and visited with the nurse for several minutes, before obtaining a cigarette and going outside to smoke. R36's progress note dated 2/24/25, at 7:42 p.m., identified R36 had tested positive for influenza A and was placed on droplet precautions. R32: R32's quarterly MDS dated 12/5/25, identified R32 was 71 years of age and had intact cognition. R32 was independent with ADL's. R32 had refused the influenza vaccine. Diagnosis included chronic obstructive pulmonary disease. R32's progress note(s) identified the following: - 2/23/25, R32 complained of chest congestion and had a temperature of 101.2. - 2/24/25, R32 was positive for influenza A and placed on droplet precautions. R32's medical record failed to identify transmission-based precautions were implemented when R34 first presented with respiratory symptoms on 2/23/25, to prevent the spread of influenza A to other residents and staff. During observations on 2/24/25, there continued to be no signs posted on the facility entrances to	F 880	then weekly thereafter to ensure transmission-based precautions are appropriately implemented when cohorting residents, beginning the week of 3/24/25. The care center will decrease these audits as compliance for TBP are achieved. The Director of Nursing and/or designee will audit that transmission-base precautions have been implemented per policy 5x/week x 2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning the week of 3/24/25, until compliance is achieved. The Director of Nursing and/or designee will conduct audits of donning/doffing of PPE with transmission-based precautions 4x/week x 2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning the week of 3/24/25, until compliance is achieved. The Director of Nursing and/or designee will conduct routine audits on all shifts 4x/week x 1 week, 2x/week x 1 week, beginning the week of 3/24/25 until 100% compliance is met on source control masking for staff, visitors, and residents. The Director of Nursing and/or designee will conduct audits to ensure proper use of PPE for transmission-based precautions, including during aerosolizing procedures 5x/week x 2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning the week of 3/24/25, until compliance is achieved. The Director of Nursing and/or designee	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 90 inform visitors and staff of influenza in the building. When interviewed on 2/24/25, at 6:10 p.m. RN-A stated when residents exhibit a cough or elevated temperature the facility encouraged the resident to stay in their room. If the resident needed to come out of their room, they were encouraged to wear a surgical mask and did not implement transmission-based precautions. The facility did not implement droplet precautions unless the resident had a positive test result for influenza. During interview on 2/24/25, at 6:29 p.m. the director of nursing (DON) stated R34 was the facility's first case of confirmed influenza. R34 tested positive for influenza A on 2/13/25 and was placed on droplet precautions on 2/14/25 and not when R34 first developed symptoms. When residents did not feel well, the facility tried to limit exposure to the ill resident until they had confirmed test results. R31 tested positive for influenza A during his visit to the emergency room and should have been isolated and placed on precautions on his return. The DON indicated she thought six other residents had some symptoms of respiratory illness and had been tested. The residents were not on transmission- based precautions but were asked to stay in their rooms as much as they could. Staff and visitors were not required to wear PPE to enter the resident rooms and some of the symptomatic residents did share their room with a roommate. The DON stated residents who exhibited any symptoms of respiratory illness should be placed in transmission based-precautions, a respiratory test completed and then placed in droplet precautions with a confirmed test however, the documentation did not reflect that.	F 880	will conduct audits on active surveillance tracking being completed per policy 3x/week x 2 weeks, 2x/week x 2 weeks, then weekly thereafter beginning the week of 3/24/25, until compliance is achieved. The Director of Nursing, Infection Preventionist or designee will review the results of audits, and monitoring with the Quality Assurance Program Improvement (QAPI) program. The internal SFHS Infection Prevention Quality Nurse Consultant is providing oversight and assistance to the care center per the DPOC paper.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 91 When interviewed on 2/24/25, at 7:33 p.m. the DON stated the facility was now implementing droplet precautions with all residents who exhibited symptoms of acute illness and not waiting for lab results before implementing the precautions. However, the facility was not doing any active surveillance for monitoring for influenza A and only obtained vital signs including temperatures weekly unless they report symptoms of illness or the facility staff notice something was off. Further, the facility had not done anything different with roommates of residents with influenza A such as isolating them or offering room changes. The DON felt when they did that during the COVID pandemic and felt it did not work and spread the illness further. During an interview on 2/26/25 at 3:41 p.m., RN-A stated she was responsible for the facility Infection Prevention and Control Program. RN-A started her role at the facility in November 2024 and worked as the facility's wound nurse as well. Staff would document any signs/symptoms of possible infections in the resident electronic medical record (EMR) and staff had the ability to initiate transmission-based precautions but had not done so until RN-A arrived to work on 2/24/25. Any resident with any sign or symptoms of infection should have been documented on the surveillance log to prevent the spread of illness. Further, the facility had not started active surveillance of residents to identify symptoms early. The facility identified via email R38 ,R7, R35 and R3 had subsequently positive influenza A tests: R38's admission MDS dated 2/12/25, identified	F 880		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 92 R38 was 63 years old and had diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis and hemiplegia (weakness of one side of the body) following a stroke and hypertension. R7's quarterly MDS dated 1/10/25, identified R7 was 91 years old and had diagnoses that included chronic obstructive pulmonary disease (COPD) (a lung condition caused by damage to the airways and alveoli), asthma and hypertension. R35's quarterly MDS dated 1/7/25, identified R7 was 79 years old and diagnoses that included hypertension and type 2 diabetes. R3's quarterly MDS dated 1/27/25, identified R3 was 92 years old and had diagnoses that included atrial fibrillation (irregular heartbeat), heart failure and chronic kidney disease. The facility Influenza A and B or Lung MDRO policy dated 9/11/17, identified in addition to standard precautions, staff were to implement droplet precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual coughing, sneezing, talking or by the performance of procedures such as suctioning. If the resident's cognition and physical ability was such that they were consistently able to cover their cough and place the tissue in a trash bag, they could come out of their room and have company without wearing a mask. The resident must be able to follow instructions and do proper hand hygiene. Place resident in a private room. if private room was not available and cohorting was not achievable, staff were	F 880		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 93 directed to use curtain in room and maintain at least three feet of space between infected resident and other residents or visitors. In addition to standard precautions, staff were to wear a mask when working within three feet of the resident. The facility Resident Influenza policy dated 5/1/24, identified influenza was a highly contagious infection of the respiratory tract caused by a virus and transmitted by air-borne droplet infections. Typical influenza illness was characterized by abrupt onset of fever/chills, myalgia, sore throat and non-productive cough. Staff were instructed to report to the charge nurse or infection prevention any suspicion of residents exhibiting influenza symptoms. Employees with a fever of 100.4 or higher should not come to work. use proper handwashing techniques, use appropriate PPE when caring for residents with symptoms of influenza. any resident with influenza symptoms or fever over 100.4 must eat in their room. Keep resident away from activities or therapies if contagious and discourage visitors. All cases of influenza would be entered on the facility infection control logs. The IJ that began on 2/13/25, was removed on 2/26/25, at 10:26 a.m., when it could be verified through observation, interview and document review the facility implemented droplet precautions for all residents that tested positive for influenza A, implemented a system for ongoing active surveillance of residents for symptoms of influenza A, implemented transmission -based precautions for all symptomatic residents until confirmatory test resulted and the facility reviewed and revised their influenza policy to reflect current CDC	F 880		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 94 guidelines. ONGOING INFECTION CONTROL SURVEILLANCE: The faciltiy provided an Infection Surveillance Report for each month that included resident name, case details, symptoms, lab results, treatment details and outcome. The facility Infection Surveillance Report dated January 2025, was reviewed and failed to include R13's influenza A exposure and symptoms. R13 R13's annual Minimum Data Set (MDS) dated 1/28/25, identified R13 had a severe cognitive impairment and diagnoses that included congestive heart failure (CHF), hypertension and type 2 diabetes. R13's nursing progress note dated 1/6/25, identified R13 was exposed to influenza A from roommate. R13 was also experiencing respiratory symptoms so R13 was swabbed for a respiratory panel which has been sent to the lab. Results pending. The facility Infection Surveillance Report dated February 2025, failed to include R34's respiratory signs and influenza A positive status, R34 R34's significant change MDS dated 2/11/25, identified R34 had a severe cognitive impairment	F 880		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 95 and diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm), hypertension and dementia. R34's nursing progress notes identified: - 2/12/25 at 4:29 p.m., R34 from a nap this afternoon with a hoarse voice and dry cough. No fever noted or any other symptoms at this time. - 2/13/25 at 2:13 p.m., R24 continued to have a hoarse voice today and dry cough. She also had a low grade temp this morning. Resp Panel swab completed at 4:00 p.m.. - 2/13/25 at 2:14 p.m., R18 was sleepy today. Was running a low grade temp this morning. R34 received scheduled Tylenol. She was complaining of pain in her right shoulder and right hip. Pain meds were effective. R34 has not eaten well today but has been drinking fluids when given to her. R34 was propelling herself around in her wheelchair more. PT works with R34 daily. - 2/13/25 at 8:33 p.m., R34 wanted to go to bed soon after supper, she appeared tired, not as talkative as usual when asked she denied any pain, no coughing noted this shift, awaiting results of resp panel. Currently R34 asleep in bed respirations easy and regular at 18. R34 was able to get place to place by wheeling wheelchair and appeared to tolerate well. - 2/14/25 at 6:51 a.m., R34 tested positive for influenza A. Isolation precautions set up on R34's door. R34 was experiencing a low grade temp, cough, and hoarse voice. A skilled nurse is monitoring signs and symptoms. Plan of care ongoing. During an interview on 2/26/25 at 3:41 p.m., RN-A stated every day RN-A was scheduled to work, RN-A read through either the 24 hour or 72 hour report. For example, if RN-A did not work the	F 880		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 880	Continued From page 96 weekend, RN-A would review the 72 hour report on Monday mornings. When RN-A was not working, there was no designated staff member to complete resident illness surveillance. Any resident with any sign or symptoms of infection should have been documented on the surveillance log to prevent the spread of illness. During an interview on 2/27/25 at 4:18 p.m., the DON stated all signs/symptoms of illness were expected to be documented and entered on the surveillance log to prevent the potential spread of illness. The facility policy Infection Surveillance revised 2/25/25, identified the facility would conduct ongoing surveillance for Healthcare-Associated Infections (Thais) and epidemiologically significant infections that have substantial impact on potential resident outcome.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		3/27/25

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 883	Continued From page 97 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883		

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 883	Continued From page 98 Based on interview and document review the facility failed to offer pneumococcal vaccination according to Centers for Disease Control (CDC) guidelines for 1 of 5 residents (R36) reviewed for vaccinations. Findings include: R36's admission Minimum Data Set (MDS) dated 12/11/24, identified R36 was admitted to the facility on 12/5/24, was 71 years old, at had diagnoses including chronic lung disease, used tobacco, and had mild cognitive impairment. The assessment identified R36 was not up to date with pneumococcal vaccination and the vaccination was not offered on admission. The undated facility immunization report identified R36 had received the PPSV23 on 11/18/19, and PCV13 on 10/31/18. R36's electronic health record did not include evidence R36 or R36's representative were offered/received education regarding pneumococcal vaccine booster(s) such as the PCV15 or PCV20 in conjunction with their provider. On 2/27/25 at 2:57 p.m., registered nurse (RN)-A stated vaccines were discussed and offered upon admission. The pneumococcal vaccine was offered according to the CDC guidance and provided individually. RN-A stated she used the PneumoRecs VaxAdvisor recommended by the CDC to help determine when pneumococcal vaccines were needed. RN-A stated R36 could have had a pneumococcal vaccine on 11/18/24. RN-A stated she should have offered the vaccine to R36 and/or R36's representative however, had not offered the vaccine.	F 883	1. R36 will be offered education on the Pneumococcal Vaccine booster and to receive the vaccine booster. 2. All residents have the potential to be affected by this deficient practice. 3. DON reviewed the Resident Immunizations policy on 3/17/25 with no changes needed. 4. DON and/or designee will educate the IPCO nurse and Case Managers on the Resident Immunizations policy, including offering pneumococcal vaccinations according to CDC guidelines to all residents. 5. IPCO and/or designee will audit all current residents' pneumococcal vaccination status. If a resident is due for a pneumococcal vaccination based on CDC recommended guidance, the resident and/or resident representative will receive education and be offered the pneumococcal vaccination. 6. DON and/or designee will audit each new admission, within 1 week, to ensure the resident and/or their representative have received education on Pneumococcal Vaccines and have been offered to receive the vaccination x 2 months, beginning the week of 3/24/25. 7. The monitoring results will be reported quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring.	

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 _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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 883	Continued From page 99 On 2/27/25 at 3:17 p.m., the director of nursing (DON) stated staff were to use the PneumoRecs vaccination website recommended by the CDC to help determine if a resident is up-to-date with their pneumococcal vaccine. The DON stated she was not aware of when residents were offered the vaccine. The Resident Immunizations policy revised 1/21/25, identified all residents would be offered vaccinations based on the CDC recommendations and physician orders. The policy further identified the facility would utilize the Adult Immunizaton Schedule, prepared by the CDC, to ensure residents were offered and encouraged to accept the appropriate vaccinations, and the determination to vaccinate or not would be documented in the residents electronic medical record.	F 883		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

Re: State Nursing Home Licensing Orders
Event ID: TMCC11

Dear Administrator:

The above facility was surveyed on February 24, 2025 through February 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/24/25 through 2/27/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with no citations were issued: H55428303C (MN00110637) and H55428385C (MN00110824) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 000	Continued From page 2 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to timely notify the physician when a hematoma (localized collection of blood outside of blood vessels) was identified and subsequently opened requiring a new intervention for 1 of 2 (R18) residents reviewed for wound care. Findings include: R18's significant change Minimum Data Set (MDS) dated 1/6/25, identified R18 had severe cognitive impairment and did not exhibit behaviors during the assessment period. Diagnoses included Alzheimer's disease and a methicillin-resistant staphylococcus aureus (MRSA) infection. R18 had an open lesion other than ulcers, rashes or cuts. No pressure, venous or arterial ulcers. R18's undated care plan, identified R18 had impaired skin integrity due to a tissue injury. Staff were directed to encourage R18 to elevate legs, R18 had an air mattress on my bed, measure ulcer on at regular intervals, monitor ulcer for signs of infection, monitor ulcer for signs of progression or declination, notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. R18's nursing progress note dated 11/22/24 at 1:15 a.m., identified a loud scream was heard and then a crash. R18 was found almost up	2 265	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 265	Continued From page 4 against the door. Staff had to push the door open until staff could fit through. Stepped over R18 walker R18 was sitting up against her closet. R18 was confused. R18 said she was just getting up. R18 did say she hurt everywhere A quick exam was done. R18 asked to be put back to bed. When R18 was put in bed, nursing assistant noted a big black bruised lump on her right inner shin. R18 continues to say she hurt everywhere. Vitals were obtained while phones calls were made to R18's son. At 1:30 am., R18's son said to send her to the emergency room. On-call RN was notified. R18's medical record failed to identify R18's hematoma until 12/12/24. R18's Skin/Wound note dated 12/12/24 at 2:19 p.m., identified the medical director (MD) was in the facility doing monthly wound rounds. R18 was sitting in the hallway in her wheelchair and nursing asked MD to take a look at R18's leg and assess. The MD examined the right calf and stated that area appeared to be a hematoma in which the skin was fully intact. R18 asked the provider if there was anything MD could give R18 to take care of it and MD told R18 that it just takes time to heal. MD stated to the current plan of care was adequate and that no further treatment was needed at this time. R18's N Adv - Skin Check dated 12/12/24 at 2:43 p.m., identified bruising purple and red inner lower right leg approximately 18 centimeter (cm) x 10cm, warm with dark purple raised area in middle of 2 cm x 2 cm, skin intact. R18's Skin/Wound note dated 12/19/24 at 7:30 a.m., identified the hematoma on R18's right leg broke open during the night and bled all over her	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 265	Continued From page 5 bed. Old dressing was taken off and the swelling had gone down, and copious amounts old blood was draining from the wound. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/19/24 at 5:03 p.m., identified wound dressing to R18's lower right extremity was changed again this afternoon due to bleeding through the dressing. Copious amounts of old blood were coming out of the hematoma wound itself. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/21/24 at 1:02 a.m., identified changed wound dressing to R18's right lower extremity due to bleeding through the dressing. The wound to mid-calf had copious amounts of serosanguineous drainage saturating the dressing. R18 tolerated dressing change without concern or complaint. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/21/24 at 10:27 a.m., identified R18 got a shower that morning. Dressing to R18's wounds on her right leg were changed and redressed. Hematoma did not have any drainage on old dressing but skin tear near the ankle had a small amount of greenish drainage noted on old dressing. The note failed to identify if R18's physician was notified of R18's change in condition. R18's nursing progress note dated 12/26/24 at 12:18 p.m., identified R18 had been out for both meals that morning. R18 denied any pain, unless she bumped her right leg on something. No new	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 265	Continued From page 6 injuries or new bruises have been noted. Dressing to her right lower extremity continued to drain and did have an odor to it. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Transfer Out of Building note dated 12/23/24 at 2:52 p.m., identified dressing change was being done on right skin, wound appears to be worsening, a photo was sent to the medical director (MD) and per MD, R18 sent to the ER. During an interview on 2/27/25 at 1:40 p.m., RN-A stated she responsible for the facility's wound care. RN-A was not aware of R18's tissue injury until 12/12/24. The MD was in the building and RN-A asked for the MD to evaluated R18. Point of care (POC) treatment (measuring and monitoring) was ordered. Then, on 12/19/24, the deep tissue injury opened. RN-A was not working that day and RN-A was not informed until 12/23/24. RN-A contacted the MD and received an order to send R18 to the emergency room for evaluation. RN-A stated the on-call RN should have contacted the physician on 12/19/24 to update on R18's condition and request dressing orders. During a phone interview on 2/27/25 at 2:43 p.m., the MD stated he was not R18's primary physician but was the medical director for the facility. The MD did evaluate R18 on 12/12/24 and R18 had a large hematoma to the upper right shin. The area was not warm to the touch or open. The MD recommended monitoring the area for changes. MD was notified on 12/19/24, R18's hematoma had opened and the MD recommended transfer to the emergency room for evaluation. Normally, the MD would expect staff to contact the primary physician unless the	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 265	Continued From page 7 physician was unavailable and to do so on 12/19/24 when R18's condition had changed. During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated any bruise/deep tissue injury should be followed and documented daily and/or when there were changes. The physician should have been notified on 12/19/24 when R18's condition had changed. The facility policy Notification of Significant Changes revised 5/22/22, identified the facility would immediately inform the resident, consult with the physician, and notify the resident representative (consistent with his or her authority), when the resident had a significant change. The primary physician will be updated during regular business hours. If the primary physician is not available, the on-call physician will be updated, and the primary provider will be sent notification. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to notification of change to the provider to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure notification of change to the provider was communicated as needed.. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. TIME PERIOD FOR CORRECTION:	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 265	Continued From page 8 TWENTY-ONE (21) days.	2 265		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was updated timely to to prevent falls for 1 of 1 residents (R19) reviewed for falls. Findings include: R18's significant change Minimum Data Set (MDS) dated 1/6/25, identified R18 had a severe cognitive impairment and diagnoses that included Alzheimer's disease, dementia and osteoporosis. R18 had a fall without injury and a fall with injury. R18 did not use an alarm or any physical or electronic device that monitored R18's movement and alerted staff when movement was detected. R18's care plan revised 2/6/25, identified R18 was at risk for all related to confusion.	2 570	corrected	3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 570	Continued From page 9 Interventions included: - Assist R18 as needed with mobility and transfers - Be sure R18's call light was within reach and encourage R18 to use it for assistance as needed. - Bed in lowest position - Ensure that R18 was wearing appropriate footwear shoes when up ambulating or mobilizing in wheelchair and gripper socks when in bed. - R18 did not remember that R18 needed assistance with transfer or ambulation, anticipate needs. - R18 had a Bed sensor on R18's wall. - R18 had an easy touch call light under sheet, under R18's hip on R18's bed. - R18 needed a safe environment with floors free from spills and/or clutter; personal items within reach, gripper strips on floor in front of bed, recliner, and toilet - Keep R18 wheelchair next to R18 during meals and activities - R18 fall risk would be assessed every quarter and with change in condition R18's Incident Forms identified the following: - 11/7/24 at 8:45 a.m., identified R18 was heard yelling out for help, she was found lying on the floor in the hallway off the dining room. R18 was laying on the floor, laying on her right side. R18 stated she was walking to eat, and her knees just gave out and she fell to her knees and then fell to her right side. R18 would have been in bed three hours prior to fall. At 7:30 a.m., staff walked resident out to the dining room for breakfast. R18 was evaluated in the emergency room. Fall interventions included: physician reviewed medications, continue with present care plan, staff to offer to assist back to room when done	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 570	Continued From page 10 with meals. However, the care plan was not revised to reflect this updated intervention. - 11/15/24 at 3:00 p.m., R18 was found lying on the floor. Fall interventions included toilet every two hours and follow care plan. However, the care plan was not revised to reflect this. - 11/22/24 at 1:15 a.m., identified R18 was found lying on the floor. Fall intervention included a flat sensor placed under sheet under hip. However, the care plan was not revised to reflect this until 12/3/24. - 11/22/24 at 11:40 p.m., identified R18 was found lying on her left side next to her bed. Fall interventions included to place flat sensor under sheet under hip on bed. Referred to maintenance t to order. However, the care plan was not revised to reflect this until 12/3/24. During an interivew on 2/27/25 at 1:09 p.m., RN-E stated R18 was at risk for falls and R18's care plan was not revised to reflect toileting every two hours and/or for staff to assist R18 back to her room after meals. During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated staff were expected to revise resident care plans with identified fall interventions and were expected to follow the care plans to attempt to prevent further falls. The facility policy Person Centered Care Planning revised 12/18/23, identified the facility would will develop a comprehensive person-centered care plan with the resident and/or family representative for each resident in the facility, consistent with the resident's rights, that included measurable	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 570	Continued From page 11 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. The resident's care plan was reviewed every 90 days or more frequently if necessary with a significant change. Care plans were updated on an ongoing basis as needed based on changes that occur between care conferences. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess each fall to ensure interventions were followed; and failed to ensure fall interventions were care planned timely and implemented to prevent falls for 1 of 1 residents (R19) reviewed for falls. Findings include: R18's significant change Minimum Data Set (MDS) dated 1/6/25, identified R18 had a severe cognitive impairment and diagnoses that included Alzheimer's disease, dementia and osteoporosis. R18 had a fall without injury and a fall with injury. R18 did not use an alarm or any physical or electronic device that monitored R18's movement and alerted staff when movement was detected. R18's Falls Care Area Assessment (CAA) dated 1/6/25, identified R18's fall risk was 27; Score 10 or higher indicated R18 was at high risk of falls. R18 was currently assistance of one staff for all transfers with the use of a mechanical lift. R18 was not able to walk, was using a manual wheelchair. R18 was able to move herself around short distances in the wheelchair and was staff assist of 1 for longer distances. R18 often attempted standing independently, staff were monitoring her closely to intervene and prevent falls. OxyCODONE HCl (narcotic pain medication) Oral Tablet 5 miligram (MG) Give 0.5 tablet by mouth every 4 hours as needed for moderate to severe pain related to CELLULITIS OF RIGHT LOWER LIMB was Prescribed by when in hospital and R18 was currently taking it. The CAA identified R18's Falls - Functional Status	2 830	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 13 would be care planned but provided no further information. R18's care plan revised 2/6/25, identified R18 was at risk for all related to confusion. Interventions included: - Assist R18 as needed with mobility and transfers - Be sure R18's call light was within reach and encourage R18 to use it for assistance as needed. - Bed in lowest position - Ensure that R18 was wearing appropriate footwear shoes when up ambulating or mobilizing in wheelchair and gripper socks when in bed. - R18 did not remember that R18 needed assistance with transfer or ambulation, anticipate needs. - R18 had a Bed sensor on R18's wall. - R18 had an easy touch call light under sheet, under R18's hip on R18's bed. - R18 needed a safe environment with floors free from spills and/or clutter; personal items within reach, gripper strips on floor in front of bed, recliner, and toilet - Keep R18 wheelchair next to R18 during meals and activities - R18 fall risk would be assessed every quarter and with change in condition However, the care plan failed to identify toileting as an intervention. R18's Incident Forms identified the following: - 11/7/24 at 8:45 a.m., identified R18 was heard yelling out for help, she was found lying on the floor in the hallway off the dining room. R18 was laying on the floor, laying on her right side. R18 stated she was walking to eat, and her knees just gave out and she fell to her knees and then fell to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 14 her right side. R18 would have been in bed three hours prior to fall. At 7:30 a.m., staff walked resident out to the dining room for breakfast. R18 was evaluated in the emergency room. Fall interventions included: physician reviewed medications, continue with present care plan, staff to offer to assist back to room when done with meals. However, the care plan was not revised to reflect this. - 11/15/24 at 3:00 p.m., R18 was laying against the entry door. Her walker was tipped over and laying against the door as well. R18's closet doors were both open and a pair of pants, still on the hanger were laying on the floor. R18 had her shoes on her feet. R18 stated that she was trying to get clothes to go in the bathroom and change. R18 was incontinent at the time of the fall. Vitals were taken and R18 was assessed. R18 does have a small hematoma on the back of her head. No other visible injuries and R18 did not have any complain of pain or discomfort. R18 was last toileted at 11:30 a.m.(3.5 hours prior). R18 was alert and oriented to her baseline, making jokes about falling on the floor. ROM was normal in both upper and lower extremities. Resident will be reviewed at the next High-Risk meeting. Fall interventions included toilet every two hours and follow care plan. However, the care plan was not revised to reflect this. - 11/22/24 at 1:15 a.m., identified a loud scream was heard and then a crash. R18 was found almost up against the door. Staff had to push the door open until staff could fit through. Stepped over R18's walker. R18 was sitting up against her closet and was confused. R18 stated she was just getting up. R18 did say she hurt everywhere. A quick exam was done. R18 asked to be put back to bed. When R18 was put in bed, the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 15 nursing assistant noted a big, black bruised lump on R18's right inner shin. R18 continued to say she hurt everywhere. Vitals were obtained while phones calls where made to R18's son. R18 was sent to the ER for evaluation. Fall intervention included a flat sensor placed under sheet under hip. However, the care plan was not revised to reflect this until 12/3/24. - 11/22/24 at 11:40 p.m., identified R18 was found lying on her left side next to her bed. Her head was positioned near the bed and her feet were towards the middle of the room. R18 had a UTI and is being treated with Cefdinir (an antibiotic) 300 miligram (mg) twice a day for 10 days. R18 had several falls recently and did have bruises from said falls. Palpated R18's head and did not find any lumps, bumps, or sore areas. R18 did have redness to left hip area. R18 denied any new pain but with dementia diagnosis R18 was not a reliable reporter/historian. R18's fall will be followed up at next High Risk Committee meeting. The Incident Form also identified staff were unsure sensor alarm was working due to no staff at the nursing station. Fall interventions included to place flat sensor under sheet under hip on bed. Referred to maintanence to order. However, the care plan was not revised to reflect this until 12/3/24. - 12/22/24 at 10:10 p.m., identified staff heard yelling and found R18 on the floor lying between closet and dresser with head close to the wall/feet pointing toward her bed. R18 was on her right side with her legs positioned under her wheelchair. R18 had right shoe on/left shoe off. Resident has dementia and was unable to tell staff what she was doing/where she was going. R18 reported that she hit her head. No bumps, lumps or sore areas found on her head. She c/o	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 16 rt hip pain while on the floor but denied pain when in bed. However, the form failed to identify interventions implemented or if staff failed to follow the care plan. - 1/31/25 at 4:11 p.m., R18 sat herself up on the edge of her bed without staff assistance and no shoes on. R18 slid from the edge of her bed to the floor with her back to the bed. Nursing assistant was rounding on residents and found R18 sitting on the floor with her back to the bed. R18 was sitting there looking as though she sat there and was just leaning against the bed. R18 had socks on her feet and no shoes on. When asked what happened R18 stated, "I was sitting on the edge of the bed and slid right of onto my butt, the bed was slippery and I didn't have my shoes on, so my socks were slippery too". Resident was assessed no Injuries noted. However, the form failed to identify interventions implemented or if staff failed to follow the care plan. During a continuous observation 2/26/25 at 9:38 a.m., R18 was assisted to lie down in bed by nursing assistant (NA)-A. NA-A did not offer toileting to R18. During an interview on 2/26/25 at 9:41 a.m., NA-A stated she did not offer toileting to R18. R18 was usually pretty continent and would say if R18 needed to use the toilet. During an interview on 2/27/25 at 11:06 a.m., NA-G stated R18 was a fall risk. R18 had a sensor in her room that told them when R18's moving and also has a touchpad call light that staff tucked under R18's side when R18 was in bed. R18 was pretty continent and did not go very often so staff did not toilet R18 every two hours.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 17 During a phone interview on 2/27/25 at 12:02 p.m., registered nurse (RN)-D stated R18 was a fall risk. R18 had a sensor on the wall in her room that told staff whenever there was movement in the room. R18 also had a touchpad call light on her mattress so if R18 tried to get out of bed it would let staff know. R18 needed to be toileted every two hours. R18 could tell staff too but R18 needed to be toileted every two hours. R18 hasn't tried to get out of bed since she came back from the hospital but R18 still had the sensors in her room. During an interview on 2/27/25 at 12:55 p.m., RN-F stated when a resident fell, an incident report was completed during the High Risk meeting, then RN-E updated the resident's care plan. R18 was a fall risk. R18 needed toileting every two hours and was able to tell you if R18 needed to go but needed help getting to and from the toilet. Staff should always offer toileting. RN-E stated R18 had memory loss and R18 might not think of it in time. It was safer for R18 to toilet, especially before lying down, because R18 wasn't waking up and trying to get out of bed. R18 did not always remember to use her call light. During an interivew on 2/27/25 at 1:09 p.m., RN-E stated R18 was at risk for falls and R18's care plan was not revised to reflect toileting every two hours and/or for staff to assist R18 back to her room after meals. During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated staff were expected to revise resident care plans with identified fall interventions and were expected to follow the care plans to attempt to prevent further falls.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 830	Continued From page 18 A facility policy regarding fall prevention was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to assessing falls and implementation of interventions. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure falls are assessed, interventions determined, care planned and staff follow the interventions as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced	2 900		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 900	Continued From page 19 by: Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 1 of 2 residents (R4); and failed to follow pressure ulcer treatments as ordered to promote healing for 1 of 2 residents (R31) reviewed for pressure ulcers.. Findings include: R4: R4's quarterly Minimum Data Set (MDS) dated 1/3/25, identified R4 was cognitively intact and had diagnoses that included peripheral neuropathy (occurs when the nerves located outside of the brain and spinal cord are damaged. It often causes weakness, numbness, and pain, typically in the hands and feet, but can also affect other areas and body functions. It is common in people with diabetes.), type 2 diabetes, congestive heart failure (CHF), venous insufficiency (occurs when the valves in the veins become damaged, allowing blood to flow backward.), and dermatitis. R4 was at risk for pressure ulcer but had no open areas. R4's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 4/16/24, identified R4 was at risk for pressure ulcer/injury and pressure ulcer/injury would be addressed on R4's care plan. However, the CAA failed to identify an analysis of the findings. R4's Braden Scale for Predicting Pressure Ulcer Risk dated 1/3/25, identified R4 was at risk for pressure ulcer and did not include any interventions. R4's care plan revised 11/22/24, included an	2 900	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 900	Continued From page 20 intervention of encouraging R4 to repositioning every two hours, and lay in bed to offload During a continuous observation on 2/26/25 at 8:26 a.m., nursing assistant (NA)-A and NA-G exited R4's room after assisting R4 with morning cares. R4 was sitting in her wheelchair. - At 8:31 a.m., R4 propelled her wheelchair to the dining room for breakfast. - At 9:16 a.m., R4 was finished with her breakfast meal and propelled her wheelchair to the activity room. No staff offered to reposition R4. - At 11:48 a.m., R4 propelled her wheelchair from the activity room to the med chart then propelled her wheelchair to common area off the dining room to watch tv. No staff offered to reposition R4. During an interview on 2/26/25 at 11:55 a.m., R4 stated she got up about 8:00 a.m. for breakfast and then went to the activity room for bible study. R4 was supposed to lay down or sit in her recliner every couple of hours. However, on 2/26/25, R4 had not laid down or sat in her recliner nor had staff offered. During an interview with NA-A and NA-G on 2/26/25 at 11:58 a.m., NA-G stated R4 was at risk for pressure ulcers, but the wound was healed "right now." Staff were supposed to offer repositioning every two hours to try to prevent the area re-opening. NA-G stated NA-G nor NA-A had offered repositioning because it had just been one of those days. During an interview on 2/26/25 at 12:07 p.m., registered nurse (RN)-A stated staff were to encourage R4 to reposition every two hours to prevent pressure ulcers.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 900	Continued From page 21 During an interview on 2/27/25 at 3:37 p.m., the director of nursing (DON) stated staff were expected to offer repositioning per the resident's care plan. R4 was at risk for skin breakdown and staff were expected to keep R4 clean and dry. R31: R31's quarterly MDS dated 11/27/24, identified R31 had intact cognition and required partial assistance with dressing. and bed mobility, and was dependent with toileting and bathing. R31 was at risk for pressure ulcer development and had one facility acquired stage two pressure ulcer and one facility acquired stage four pressure ulcer present. R31 also had one stage two pressure ulcer that was present on admission. R31's diagnoses included congestive heart failure, and diabetes. R31's careplan dated 11/25/24, identified R31 had actual impairment to skin integrity of the left back calf and right heel related to deep tissue injury. Interventions included to elevate left leg so the wound would not touch the bed, float heels, use lambs wool under legs and feet, turn and reposition every two to three hours, and observe skin daily with cares, R31's Order Summary Report dated 2/27/25, directed staff to complete daily monitoring and documentation every shift for pressure ulcers located on right heel, left ankle and left mid calf. Physician ordered right heel wound care and left calf wound care included to remove wound dressing to both wounds, irrigate the wounds with sterile water, pat dry, apply a woven gauze wet to dry dressing and wrap both wounds with rolled gauze daily.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 900	Continued From page 22 On 2/25/25, at 3:03 p.m. registered nurse (RN)-A entered R31's room after putting on a gown, gloves and mask. RN-A laid out the necessary supplies to complete R31's ordered wound care on a disposable pad on R31's bed stand. RN-A uncovered R31's leg and proceeded to remove the dressing on R31's left calf. The dressing was dated 2/23/25 with black marker, two days before. Gauze packing was removed from the wound and was saturated with dried, serosanguinous drainage. RN-A irrigated the wound with sterile water and applied the wet to dry gauze and rolled gauze as ordered, dating the new dressing 2/25/25. After changing gloves, RN-A lifted R31's right leg up to assess his right heel. The heel was open to air, dry appearing serosanguinous drainage covered an eight inch area of the fitted sheet on the foot of the bed. A rolled gauze and folded gauze dressing was loosely wrapped around R31's right calf and was dated 2/23/25. RN-A cut off the old dressing that had slid up from R31's right heel wound. No drainage was visible on the old dressing. RN-A irrigated the right heel wound and applied the new dressing as ordered and dated the dressing 2/25/25. RN-A stated R31 must not have gotten his dressing changed the day before as ordered. R31's Treatment Administration Record (TAR) for February 2025, identified monitoring and documentation of right heel, left ankle and left mid calf pressure ulcers were not signed off completed on February 17, 19, 20, 22, and 25. Physician ordered daily dressing change to right heel had not been signed off completed for February 21, 22, and 25 Physician ordered daily dressing change to left calf had not been signed off completed on February 17,19, 20, 22, and 25. When interviewed on 2/27/25, at 9:28 RN-F	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 900	Continued From page 23 stated if an order on a resident's TAR was not initialed she would assume that to mean it had not been done that day. During interview on 2/27/25, at 9:44 a.m. RN-B stated if an order on a resident's TAR was not initialed off it could mean it had not been done. R31's dressings needed to be completed daily so they could monitor for symptoms of infection and drainage and make sure his wounds were not getting any worse. During interview on 2/27/25, at 2:12 p.m. the DON stated she expected R31's dressings to be completed daily as ordered to help R31's wounds heal and prevent infection. The facility policy Skin Integrity dated 11/26/24, identified the facility would assess each resident's risk for skin integrity issues at move in, quarterly, with any significant change in condition, and with a new or potential pressure ulcer and will identify interventions to help prevent skin integrity issues. Residents at risk for skin breakdown would have preventative measures implemented such as repositioning plan and pressure redistribution devices. The Care plan would address the resident needs, goals, and interventions based on the skin assessment and resident/representative input. Interventions will be implemented, reviewed, and updated for appropriateness. Further, pressure ulcers would be observed daily. Documentation would include evaluation of the pressure ulcer, evaluation of the status of the dressing, status of the surrounding area, presence of complications and pain if present. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to pressure	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 900	Continued From page 24 ulcers to meet the needs of each individual resident. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure notification of change to the provider was communicated as needed TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure assistance was offered with meal setup to promote safety and independence with eating for 1 of 1 resident (R38) reviewed for activities of daily living (ADL)	2 915	corrected	3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 915	Continued From page 25 and needed set up and supervision to eat. Findings include: R38's admission Minimum Data Set (MDS) dated 2/12/25, identified R38 had intact cognition and required supervision or touching assistance with eating, maximum assistance with dressing and grooming and was dependent on staff for toileting, and transfers. Diagnoses included hemiplegia following cardiovascular disease and venous insufficiency. R38's Occupational Therapy (OT) Evaluation dated 2/7/25, identified R38 required supervision with eating and assistance to cut up his food. R38's Speech-Language Pathology Evaluation dated 2/11/25 identified R38 was edentulous (without teeth) and had top and bottom dentures but chose not to wear them. R38 was admitted on a soft and bite sized diet. R38 reported he was not having difficulty with regular textured food and would like to be upgraded. R38's progress note(s) identified the following: - 2/6/25, identified R38 was eating lunch in his room when his friend came to visit. The friend was upset that the lunch tray had been left for R38 in his room but had not been prepared so he could eat it. It was determined R38 should eat in dining area for his meals to ensure he received the assistance when needed. - 2/12/25, R38 required supervision with eating and setup of his meal trays. R38 was a choking risk and was required to be in the dining room for meals to be observed. R38 was unable to cut up his foods and required food to be cut up small to prevent choking.	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 915	Continued From page 26 R38's care plan dated 2/12/25, identified R38 had a swallowing problem related to coughing or choking during meals or swallowing medications. Interventions included for all staff to be informed of resident's special dietary and safety needs, eat only with supervision and to instruct R38 to eat in upright position, eat slowly and chew each bite thoroughly. R38 had hemiparesis on his left side and staff were to discuss concerns or issues regarding diagnosis. R38's care plan failed to identify R38's preference to have his food cut into small bites and/or his inability to cut up the food into small bites himself due to limited range of motion as assessed by OT. On 2/25/25, at 12:05 p.m. R38 was observed sitting at the dining room at a table in the back, away from most of the other residents and staff. R38 was served a sloppy Joe bun cut into quarters, whole french fries, a lettuce salad and two cups of liquid in covered cups with straws. R38 made no attempt to eat and remained seated in his wheelchair with his hands in his lap. At 12:25 p.m. R38 stated he was hungry but he did not think he could eat the food in front of him. He needed it cut up or something different. Three staff members were in the dining room assisting other residents, however, no one approached R38 to offer assistance. At 12:44 p.m. R38 remained seated in his wheelchair with his hands in his lap and food untouched. No staff approached him to offer assistance. At 4:47 p.m. the director of nursing (DON) approached R38 and asked if she could assist him. R38 stated he was hungry but could not eat the meal and needed to have help to cut it up. The DON noticed R38 was overly warm and obtained another staff member to assist him to his room, bringing his lunch tray with him.	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 915	Continued From page 27 During joint interview on 2/27/25, at 9:10 a.m. with nursing assistant (NA)-A and NA-H, NA-A stated R38 did not need help to eat but needed to eat in the dining room for supervision. NA-H stated R38 needed to have his food cut up in very small bites in order for him to eat. When interviewed on 2/27/25, at 9:44 a.m. registered nurse (RN)-B stated it was an issue if R38 had not gotten assistance to cut his food in small pieces. Cutting his sloppy Joe bun into quarters and serving whole baked french fries was not small bite size pieces and she was not sure if he should have even been served french fries as they would be difficult for him to eat. When staff put the plate of food in front of him they should immediately cut up the food into small bite size pieces. RN-B always asked R38 what she could do for him when she delivered his food. RN-B stated residents should be checked on in the dining room and 45 minutes was to long not to have someone to have had checked with him and offer assistance. During interview on 2/27/25, at 1:45 p.m. dietary aide (DA)-A stated if a resident had an order to have food cut up small and bite sized, the dietary staff would do that before serving the resident the meal. A sandwich cut into quarters and whole crispy french fries would not be considered small and bite sized. DA-A did not think R38 had an order for small bite sized food anymore. R38 had graduated to a regular diet level and just could not have any food on the bone and his bacon needed to be soft. The dietary order indicated he was to take small bites and sips and alternate between bites and sips but not for dietary to cut up the food in small bites. R38's medical record lacked documentation	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
2 915	Continued From page 28 R38's dietary needs, assistance with eating and food preferences had been reassessed, after being upgraded to a regular diet. During interview on 2/27/25, at 2:12 p.m. the director of nursing (DON) stated staff should have checked with R38 in the dining room when he had not attempted to eat. There wasn't a physician order to cut up R38's food in small bite size pieces but she would have expected the intervention to be on his care plan or at least to offer assistance with every meal. The facility's undated policy Activities of Daily Living, identified the purpose was to provide assistance to residents as necessary, to supervise and assess resident function in order to plan care to maintain optimum ADL function and to improve quality of life. SUGGESTED METHOD OF CORRECTION: The DON or designee, could review all residents that need assistance with dining to assure they are receiving the necessary treatment/services. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure notification of change to the provider was communicated as needed. TIME PERIOD OF CORRECTION: Twenty-one (21) days	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement transmission-based precautions (TBP) for respiratory symptoms until confirmatory respiratory test results were obtained for 6 of 38 residents (R34, R31, R11,R22, R36, R32), failed to initiate droplet precautions for 1 of 6 residents (R31) known to test positive for influenza A, failed to implement strategies to mitigate the risk of an influenza outbreak, including initiating active surveillance of residents for signs and symptoms of influenza A, isolation of residents presenting with symptoms of influenza A, and post signage at the facility entrances to notify visitors of active illness in the facility. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility when 8 of 38 residents (R31, R11 , R36, R32, R38, R7, R35, R3) contracted influenza A. In addition, the facility failed to track and trend all resident actual/potential infection on the monthly tracking form to effectively identify symptoms and reduce the spread of infection with a potential to affect all 38 residents residing in the facility. Findings include: INFLUENZA A OUTBREAK: The Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities from the Centers of Disease Control (CDC) dated 9/17/24, identified influenza can be introduced into a long-term care facility by newly admitted residents, healthcare personnel, and visitors. Spread of influenza can occur	21375	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 30 between and among residents, healthcare personnel and visitors. Residents of long-term care facilities can experience severe and fatal illness during influenza outbreaks. If one laboratory-confirmed influenza positive case was identified along with other cases of acute respiratory illness in a unit of a long-term care facility, an influenza outbreak might be occurring. Active surveillance for additional cases should be implemented as soon as possible once one case of laboratory-confirmed influenza is identified in a facility. When 2 cases of laboratory-confirmed influenza were identified within 72 hours of each other in residents on the same unit, outbreak control measures should be implemented as soon as possible. Droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Droplet Precautions should be implemented for residents with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a resident is in a healthcare facility. The CDC guidance for Flu and People 65 Years and Older dated 9/5/24, identified people 65 years and older are at higher risk of developing serious flu complications compared with young, healthy adults. This increased risk is due in part to changes in immune defenses with increasing age. While flu seasons vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease. In recent years, for example, it ' s estimated that between 70 percent and 85 percent of seasonal flu-related deaths have occurred in people 65 years and older, and between 50 percent and 70 percent of	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 31 seasonal flu-related hospitalizations have occurred among people in this age group. On 2/24/25, at 11:30 a.m. surveyors entered the facility to conduct an annual recertification survey. No signs were posted to alert visitors an influenza outbreak was occurring in the facility. During the entrance conference 2/24/25, at 12:26 p.m. with the DON, the DON failed to identify there were any residents ill with respiratory illness or the facility may be experiencing an influenza outbreak. R34: R34's significant change Minimum Data Set (MDS) dated 2/11/25, identified R34 was 84 years of age and had moderately impaired cognition. R34 required maximum assistance with most activities of daily living (ADLs). R34 was vaccinated for influenza on 10/11/24. Diagnoses included Alzheimer's disease, acute kidney failure and encephalopathy. R34's progress notes identified on 2/12/25, R34 had developed a hoarse voice and dry cough and on 2/13/25, R31 had developed a low-grade temperature. A positive influenza test was identified on 2/14/25. Droplet precautions were put into place on 2/14/25. R34's medical record failed to identify transmission-based precautions were implemented when R34 first presented with respiratory symptoms to prevent the spread of influenza A to other residents and staff. R31: R31's quarterly MDS dated 11/27/24, identified R31 was 68 years of age and had intact	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 32 cognition. R31 required partial assistance with dressing and was dependent with toileting and bathing. R31 was vaccinated for influenza on 10/10/24. Diagnoses included congestive heart failure, and diabetes. R31's progress note on 2/23/25, identified R31 complained of not feeling well with body aches and wheezes noted in both lung fields. R31 was sent to the emergency room to be evaluated and returned on 2/24/25, at 2:20 a.m. with a positive influenza A test result. R31's medical record failed to identify droplet precautions were implemented when R34 returned from the hospital positive for influenza A, to prevent the spread of influenza A to other residents and staff. On 2/24/25, at 3:20 p.m. prior to the surveyor entering the room for screening nursing assistant (NA)-A stated R31 was on enhanced barrier precautions because R31 had a catheter in place. Staff were required to wear gown and gloves when providing close contact care. The personal protective equipment (PPE) was not required to visit with resident if not in close contact with resident. The surveyor proceeded to enter the room to complete the screening process for the survey. On 2/24/25, at 4:46 p.m. trained medication aide (TMA)-A was observed removing the enhanced barrier precaution sign on R31's door and placing a droplet precaution sign on the door. During interview on 2/24/25, at 4:46 p.m. TMA-A stated R31 only had enhanced barrier precautions sign on his door, which directed staff to gown and glove when providing personal care	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 33 and did not require staff to mask. TMA-A had just put a new droplet precaution sign on R31's door that directed all persons to gown, glove, and mask prior to entering the room. TMA-A stated all the staff working that day were aware R31 had tested positive for influenza A since his return from the emergency room at 2:30 a.m., as it was reported during shift report that morning. The precautions sign had just not been changed. (the droplet precautions were placed 13 1/2 hours later) When interviewed on 2/24/25, at 4:59 p.m. the infection preventionist registered nurse (RN)-A stated R31's precautions should have been changed from enhanced barrier precautions to droplet precautions as soon as he returned from the emergency department. R11: R11's admission MDS dated 11/21/24, identified R11 was 87 years of age and had severe cognitive impairment. R11 required moderate assistance with dressing, bathing, and toileting. R11 was vaccinated for influenza prior to his admission to the facility. Diagnoses included malignant neoplasm of the rectal sigmoid junction and thrombocytopenia. R11's progress note(s) identified on 2/24/25, R11 had required administration of acetaminophen 650 milligrams at 7:54 a.m. for a temperature of 101.4. On 2/24/25, at 1:13 p.m. a family member (FM)-A was observed sitting on R11's bed, in very close contact with R11, who was seated in his recliner in his room. FM-A stated R11 had a temperature that morning and had fallen getting out of bed as he was so weak. The facility had tested him for	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 34 respiratory illness and were waiting on the results. FM-A was not wearing any PPE and there was no evidence transmission-based precautions were not implemented with close contact with R11. During observation on 2/24/25, at 1:20 p.m. two unidentified nursing assistants (NA) were seen entering R11's room to assist his roommate R14 to bed. R11 was seated in his recliner in the room, next to the fully open privacy curtain. The NAs drew the privacy curtain halfway across the room and assisted R14 to bed using a mechanical lift. The NAs re-opened the privacy curtain, used alcohol-based hand rub on their hands after completing the task and exited the room. Neither NA's put on personal protective equipment. There was no signage or PPE cart outside of R11's room to alert staff to the need for PPE when entering the room to prevent potential transmission to others. On 2/24/25, at 6:18 p.m. NA-C and NA-D were observed assisting R11 to the bathroom. NA-C, wearing mask and gloves, was kneeling in front of R11 who was seated on the toilet. NA-D was outside of the bathroom making the bed up. NA-D did not have gown or mask on. NA-D stated she remembered someone mentioning something about wearing a mask but had forgotten. NA-D exited the room to read the precaution sign posted on R11's room door. The sign indicated R11 was on droplet precautions, and everyone must wear a mask and clean hands on entering and leaving the room. If contact with secretions were likely staff were directed to use gown, gloves and eye cover as well. NA-D stated she now realized she needed to wear a gown and mask. NA-D put on a gown and surgical mask and brought NA-C an isolation gown to put on.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 35 R11's progress note on 2/24/25, at 6:31 p.m. identified R11 tested positive for influenza A and was placed on droplet precautions. Appropriate signage and a PPE cart were placed outside of his door. R22: R22's admission MDS dated 1/17/25, identified R22 was 77 years of age and had severe cognitive impairment. R22 required supervision with ADL's. R22 had not been vaccinated for influenza virus. Diagnoses included neurocognitive disorder with Lewy bodies, and heart disease. During observation on 2/24/25, between 1:00 p.m., to 5:30 p.m. R22 was lethargic, lying halfway on his bed with both feet on the floor. R22 did not wake to eat lunch. At 2:00 PM. TMA-A and another unidentified staff member were attempting to arouse R22 to drink water. Neither staff were wearing any PPE. There were no isolation precautions or PPE cart noted in the room. R22's progress note(s) identified the following: - 2/24/25, at 11:09 a.m. a respiratory panel was completed for cough, headache and body aches. - 2/24/25, at 2:02 p.m. identified R22 had been wandering throughout the shift, into other resident rooms and was difficult to redirect. - 2/24/25, at 7:20 p.m. identified R22 had not been feeling well that day and had complained of ear pain, neck pain and headache R22 had a temperature of 100.4 and oxygen saturation was 92%. A respiratory panel had been completed with results pending. R22 was sent to the emergency room for further evaluation.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 36 - 2/25/25, at 3:21 a.m. identified R22 had returned from the emergency room. R22's respiratory panel was negative, however, R22 continued to complain of neck pain, refused to eat his meals and remained in bed. R22's medical record failed to identify transmission-based precautions were implemented when R22 first presented with respiratory symptoms on 2/24/25, to prevent the spread of potential respiratory infections to other residents and staff. R36: R36's admission MDS 12/11/24, identified R36 was 71 years of age and had intact cognition. R36 was independent with his ADLs. R36 had been vaccinated for the influenza prior to his admission to the facility. Diagnoses included chronic obstructive pulmonary disease, irritable bowel syndrome, and abnormal weight loss. During interview on 2/24/25, at 2:51 p.m. R36 stated he was not feeling well and had not eaten much in two weeks. R36 reported he had fallen that morning because he was so weak. There were no isolation precautions, signage or PPE cart noted in the room. On 2/24/25, at 3:28 p.m. R36 was observed dressed in coat, hat and gloves, ambulating down the hallway. R36 stated he was going outside to smoke a cigarette. R36 stopped at the nurse's station and visited with the nurse for several minutes, before obtaining a cigarette and going outside to smoke. R36's progress note dated 2/24/25, at 7:42 p.m., identified R36 had tested positive for influenza A	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 37 and was placed on droplet precautions. R32: R32's quarterly MDS dated 12/5/25, identified R32 was 71 years of age and had intact cognition. R32 was independent with ADL's. R32 had refused the influenza vaccine. Diagnosis included chronic obstructive pulmonary disease. R32's progress note(s) identified the following: - 2/23/25, R32 complained of chest congestion and had a temperature of 101.2. - 2/24/25, R32 was positive for influenza A and placed on droplet precautions. R32's medical record failed to identify transmission-based precautions were implemented when R34 first presented with respiratory symptoms on 2/23/25, to prevent the spread of influenza A to other residents and staff. During observations on 2/24/25, there continued to be no signs posted on the facility entrances to inform visitors and staff of influenza in the building. When interviewed on 2/24/25, at 6:10 p.m. RN-A stated when residents exhibit a cough or elevated temperature the facility encouraged the resident to stay in their room. If the resident needed to come out of their room, they were encouraged to wear a surgical mask and did not implement transmission-based precautions. The facility did not implement droplet precautions unless the resident had a positive test result for influenza. During interview on 2/24/25, at 6:29 p.m. the director of nursing (DON) stated R34 was the	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 38 facility's first case of confirmed influenza. R34 tested positive for influenza A on 2/13/25 and was placed on droplet precautions on 2/14/25 and not when R34 first developed symptoms. When residents did not feel well, the facility tried to limit exposure to the ill resident until they had confirmed test results. R31 tested positive for influenza A during his visit to the emergency room and should have been isolated and placed on precautions on his return. The DON indicated she thought six other residents had some symptoms of respiratory illness and had been tested. The residents were not on transmission- based precautions but were asked to stay in their rooms as much as they could. Staff and visitors were not required to wear PPE to enter the resident rooms and some of the symptomatic residents did share their room with a roommate. The DON stated residents who exhibited any symptoms of respiratory illness should be placed in transmission based-precautions, a respiratory test completed and then placed in droplet precautions with a confirmed test however, the documentation did not reflect that. When interviewed on 2/24/25, at 7:33 p.m. the DON stated the facility was now implementing droplet precautions with all residents who exhibited symptoms of acute illness and not waiting for lab results before implementing the precautions. However, the facility was not doing any active surveillance for monitoring for influenza A and only obtained vital signs including temperatures weekly unless they report symptoms of illness or the facility staff notice something was off. Further, the facility had not done anything different with roommates of residents with influenza A such as isolating them or offering room changes. The DON felt when they did that during the COVID pandemic and felt	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 39 it did not work and spread the illness further. During an interview on 2/26/25 at 3:41 p.m., RN-A stated she was responsible for the facility Infection Prevention and Control Program. RN-A started her role at the facility in November 2024 and worked as the facility's wound nurse as well. Staff would document any signs/symptoms of possible infections in the resident electronic medical record (EMR) and staff had the ability to initiate transmission-based precautions but had not done so until RN-A arrived to work on 2/24/25. Any resident with any sign or symptoms of infection should have been documented on the surveillance log to prevent the spread of illness. Further, the facility had not started active surveillance of residents to identify symptoms early. The facility identified via email R38 ,R7, R35 and R3 had subsequently positive influenza A tests: R38's admission MDS dated 2/12/25, identified R38 was 63 years old and had diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis and hemiplegia (weakness of one side of the body) following a stroke and hypertension. R7's quarterly MDS dated 1/10/25, identified R7 was 91 years old and had diagnoses that included chronic obstructive pulmonary disease (COPD) (a lung condition caused by damage to the airways and alveoli), asthma and hypertension. R35's quarterly MDS dated 1/7/25, identified R7 was 79 years old and diagnoses that included hypertension and type 2 diabetes.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 40 R3's quarterly MDS dated 1/27/25, identified R3 was 92 years old and had diagnoses that included atrial fibrillation (irregular heartbeat), heart failure and chronic kidney disease. The facility Influenza A and B or Lung MDRO policy dated 9/11/17, identified in addition to standard precautions, staff were to implement droplet precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual coughing, sneezing, talking or by the performance of procedures such as suctioning. If the resident's cognition and physical ability was such that they were consistently able to cover their cough and place the tissue in a trash bag, they could come out of their room and have company without wearing a mask. The resident must be able to follow instructions and do proper hand hygiene. Place resident in a private room. if private room was not available and cohorting was not achievable, staff were directed to use curtain in room and maintain at least three feet of space between infected resident and other residents or visitors. In addition to standard precautions, staff were to wear a mask when working within three feet of the resident. The facility Resident Influenza policy dated 5/1/24, identified influenza was a highly contagious infection of the respiratory tract caused by a virus and transmitted by air-borne droplet infections. Typical influenza illness was characterized by abrupt onset of fever/chills, myalgia, sore throat and non-productive cough. Staff were instructed to report to the charge nurse or infection prevention any suspicion of residents exhibiting influenza symptoms. Employees with a fever of 100.4 or higher should not come to work.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 41 use proper handwashing techniques, use appropriate PPE when caring for residents with symptoms of influenza. any resident with influenza symptoms or fever over 100.4 must eat in their room. Keep resident away from activities or therapies if contagious and discourage visitors. All cases of influenza would be entered on the facility infection control logs. The IJ that began on 2/13/25, was removed on 2/26/25, at 10:26 a.m., when it could be verified through observation, interview and document review the facility implemented droplet precautions for all residents that tested positive for influenza A, implemented a system for ongoing active surveillance of residents for symptoms of influenza A, implemented transmission -based precautions for all symptomatic residents until confirmatory test resulted and the facility reviewed and revised their influenza policy to reflect current CDC guidelines. ONGOING INFECTION CONTROL SURVEILLANCE: The faciltiy provided an Infection Surveillance Report for each month that included resident name, case details, symptoms, lab results, treatment details and outcome. The facility Infection Surveillance Report dated January 2025, was reviewed and failed to include R13's influenza A exposure and symptoms. R13 R13's annual Minimum Data Set (MDS) dated 1/28/25, identified R13 had a severe cognitive impairment and diagnoses that included congestive heart failure (CHF), hypertension and	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 42 type 2 diabetes. R13's nursing progress note dated 1/6/25, identified R13 was exposed to influenza A from roommate. R13 was also experiencing respiratory symptoms so R13 was swabbed for a respiratory panel which has been sent to the lab. Results pending. The facility Infection Surveillance Report dated February 2025, failed to include R34's respiratory signs and influenza A positive status, R34 R34's significant change MDS dated 2/11/25, identified R34 had a severe cognitive impairment and diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm), hypertension and dementia. R34's nursing progress notes identified: - 2/12/25 at 4:29 p.m., R34 from a nap this afternoon with a hoarse voice and dry cough. No fever noted or any other symptoms at this time. - 2/13/25 at 2:13 p.m., R24 continued to have a hoarse voice today and dry cough. She also had a low grade temp this morning. Resp Panel swab completed at 4:00 p.m.. - 2/13/25 at 2:14 p.m., R18 was sleepy today. Was running a low grade temp this morning. R34 received scheduled Tylenol. She was complaining of pain in her right shoulder and right hip. Pain meds were effective. R34 has not eaten well today but has been drinking fluids when given to her. R34 was propelling herself around in her wheelchair more. PT works with R34 daily. - 2/13/25 at 8:33 p.m., R34 wanted to go to bed soon after supper, she appeared tired, not as talkative as usual when asked she denied any pain, no coughing noted this shift, awaiting results	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 43 of resp panel. Currently R34 asleep in bed respirations easy and regular at 18. R34 was able to get place to place by wheeling wheelchair and appeared to tolerate well. - 2/14/25 at 6:51 a.m., R34 tested positive for influenza A. Isolation precautions set up on R34's door. R34 was experiencing a low grade temp, cough, and hoarse voice. A skilled nurse is monitoring signs and symptoms. Plan of care ongoing. During an interview on 2/26/25 at 3:41 p.m., RN-A stated every day RN-A was scheduled to work, RN-A read through either the 24 hour or 72 hour report. For example, if RN-A did not work the weekend, RN-A would review the 72 hour report on Monday mornings. When RN-A was not working, there was no designated staff member to complete resident illness surveillance. Any resident with any sign or symptoms of infection should have been documented on the surveillance log to prevent the spread of illness. During an interview on 2/27/25 at 4:18 p.m., the DON stated all signs/symptoms of illness were expected to be documented and entered on the surveillance log to prevent the potential spread of illness. The facility policy Infection Surveillance revised 2/25/25, identified the facility would conduct ongoing surveillance for Healthcare-Associated Infections (Thais) and epidemiologically significant infections that have substantial impact on potential resident outcome. Suggested Method of Correction: The DON or designee could review/revise facility policies to ensure they contain all components of an infection control program, including	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21375	Continued From page 44 tracking/trending of all illnesses, identification of illness' and when to initiate and remove PPE, how to mitigate an outbreak of a respiratory illness.ne pathogens. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure the infection control program is identify and tracking actual/potential infections in real time and implement the appropriate precautions to reduce the spread of infection in the facility. Time Period for Correction: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21426	Continued From page 45 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a tuberculin skin testing (i.e., TST) and/or an IGRA (test used to determine presence of Tuberculosis (TB)) along with a screening for TB symptoms was completed upon admission for 1 of 5 residents (R31) reviewed for tuberculosis practices. Findings include: R31's quarterly Minimum Data Set (MDS) dated 11/27/24, identified R31 was admitted on 8/22/24. R31's diagnoses included coronary artery disease, heart failure, hypertension, renal disease, diabetes, and malnutrition. R31's medical record lacked evidence that an assessment for risk factors and physical screening for active symptoms of TB had been completed. Further, R31's medical record lacked evidence that either an IGRA or TST series had been completed for R31 despite admitting several months prior. On 2/27/25 at 2:50 p.m., registered nurse (RN)-A stated all residents are tested for TB via a blood test. RN-A verified she had reviewed R31's medical record and acknowledged it lacked documentation to demonstrate a TB screening and TST or IGRA had been completed. RN-A stated the TB screening and test should have been completed upon admission. On 2/27/25 at 3:17 p.m., the director of nursing (DON) stated a resident TB screen was completed upon admission for all residents. DON stated R31 did not have a TB screen and TST or	21426	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21426	Continued From page 46 IGRA completed and should have. The Resident Tuberculosis Prevention and Control policy revised 1/21/25, identified each resident admitted to the care center would be required to have a written assessment of the resident's risk factors for TB along with any current TB symptoms. An Interferon-Gamma Release Assay Test (T-Spot or TB Gold) or a standard two-step TST would be initiated within 72 hours after admission to the care center and would be documented in the resident electronic medical record. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one-(21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist	21530		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 47 currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by:	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 48 Based on interview and document review, the facility failed to ensure the consulting pharmacist recommendations were addressed and acted upon and documented in the medical record for 3 of 5 residents (R11, R22, R36) reviewed for unnecessary medication use. Findings include: R11: R11's admission Minimum Data Set (MDS) dated 11/21/24, identified R11 had severe cognitive impairment and diagnoses included Alzheimer's disease and malignant neoplasm of rectal sigmoid junction. R11's Order Summary Report dated 2/17/25, identified R11's current medication regimen with their corresponding start dates. This included an order for quetiapine (an antipsychotic) 25 mg one tablet at bedtime related to dementia with other behavioral disturbances with order date 11/26/24. R11's completed Consultant Pharmacist's Medication Review, dated December 2024, identified R11's medication regimen was reviewed and an irregularity was listed involving R11's medication quetiapine with related to the indication for the medication was listed as dementia with anxiety and no behavioral disturbance. The suggested course of action identified it was prudent to verify the accuracy for low dose quetiapine as these sometimes were not appropriate to continue. Please verify the indication accuracy. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it and providing a rational and the resident was on the lowest effective does. The review was requested	21530	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 49 for "... ASAP [as soon as possible] but no later than 30 days." R11's medical record lacked evidence the consulting pharmacist's recommendation on R11's quetiapine dose irregularity had been forwarded, reviewed and/or acted upon by the physician. When interviewed on 2/27/25, at 2:12 p.m. the director of nursing (DON) stated a dementia diagnosis was not enough to prescribe quetiapine and she planned to speak with the provider regarding the issue. During telephone interview on 2/27/25, at 12:54 p.m. the consulting pharmacist (CP)-E stated she made a recommendation in December dementia was not an appropriate diagnosis to prescribe quetiapine. When CP-E had spoken with the DON she had been told everything was addressed by the physician in January, then it was discovered it had not been. During telephone interview on 2/27/25, at 3:29 p.m. R11's primary provider (DR)-A stated when the medication is ordered, a diagnosis pops up and he had chosen it. DR-A was not aware of the regulations and nobody had brought the issue up to him when he conducting rounds at the facility. DR-A did the medical rounds and the mental health practioner nurse practioner (NP)-F did the mental health rounds. NP-F would be more aware of the regulations regarding those medications. On 2/27/25, at 4:01 p.m. NP-F was called with a request for a return call, however, none was received. R22:	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 50 R22's admission MDS dated 1/17/25, identified R22 had severe cognitive impairment and diagnoses included neurocognitive disorder with Lewy bodies dementia. R22's Order Summar Report dated 1/12/25, identified current medication regimen with their corresponding start dates. Including the following as needed (PRN) orders: -quetiapine 25 milligrams (mg) by mouth (po) every 24 hours as needed for anxiety/agitation. Start Date of 1/10/25, with no end date ordered. R22's Order Summary Report dated 2/3/25, identified current medication regimen with their corresponding start dates. Including the following as needed PRN orders: -haloperidol injection 5mg/milliliter (ml) inject 0.5 ml intramuscularly (IM) every hour PRN for agitation/aggressive behaviors related to neurocognitive disorder with lewy bodies. Start date of 1/22/25, with no end date ordered. -lorazepam injection 2 mg/ml inject 0.5 ml IM as needed for agitation. May have up to two doses daily after 30 minute interval. Start date of 1/22/25, with no end date ordered. -lorazepam 1 mg by mouth (po) every four hours PRN for agitation and aggression. Start date 1/19/25, with no end date ordered. -olanzepine 5 mg tablet, give one tablet every 12 hours PRN for agitation related to neurocognitive disorder with lewy bodies. Start date of 1/22/25, with no end date ordered. R22's completed Consultant Pharmacist's Medication Review, dated January 2025, identified R22's medication regimen was reviewed and an irregularity was identified involving R22's PRN medication quetiapine with	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 51 comment that PRN antipsychotic medications were limited to a 14 day duration based on CMS guidelines. When prescribing PRN antipsychotic's the medical record would include indication/clinical need, dose and frequency of use. If the treatment was to be extended after the initial treatment duration had ended, the resident must be re-evaluated and a new order provided each time. The suggested course of action listed was to re-evaluate the clinical appropriateness of the current therapy. Add a 14 day stop date to the antipsychotic and if the treatment was to be continued, to perform a clinical evaluation/examination of the resident and provide a new order as specified above after the initial 14 days. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days." R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen had been reviewed and irregularity was listed involving R22's PRN medication haloperidol injections with comment that R22 was admitting with an order for a PRN antipsychotic medication, however, there was no stop date/duration indicated on the order. Per CMS guidelines, PRN antipsychotic orders must be limited to a 14 days. Additionally, guidelines require a face to face provider evaluation, documentation of clinical rationale and a new order with a 14 day stop date to continue the PRN antipsychotic. The suggested course of action listed was to ensure all new PRN antipsychotic orders were accompanied by 14 day stop dates. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it it, it was	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 52 requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days." R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen was reviewed and an irregularity was identified involving R22's PRN medication lorazepam tablet with comment PRN psychotropic such as lorazepam were limited to a 14 day duration based on updated CMS guidance and rules unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. When prescribing PRN psychotropics, the medical record should include the indication/clinical need, dose and frequency of use. If treatment was to be extended after the pintail treatment duration had ended, the resident must be re-evaluated and a new order provided. The suggested course of action listed was to reevaluate appropriateness of the continued therapy. If continued to add an appropriate stop date for the psychotropic medication and document duration of threaten and clinical evaluation/rationale of the resident. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days." R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen was reviewed and an irregularity was identified involving R22's PRN medication lorazepam injection with comment PRN psychotropics such as lorazepam were limited to a 14 day duration based on updated CMS guidance and rules unless the prescriber chose to extend treatment	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 53 by providing clinical rationale and documentation of intended duration. When prescribing PRN psychotropics, the medical record should include the indication/clinical need, dose and frequency of use. If treatment was to be extended after the pintail treatment duration had ended, the resident must be re-evaluated and a new order provided. The suggested course of action listed was to reevaluate appropriateness of the continued therapy. If continued to add an appropriate stop date for the psychotropic medication and document duration of threaten and clinical evaluation/rationale of the resident. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days." R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen had been reviewed and irregularity was listed involving R22's PRN medication olanzapine with comment that R22 was admitted with an order for a PRN antipsychotic medication, however, there was no stop date/duration indicated on the order. Per CMS guidelines, PRN antipsychotic orders must be limited to a 14 days. Additionally, guidelines require a face to face provider evaluation, documentation of clinical rationale and a new order with a 14 day stop date to continue the PRN antipsychotic. The suggested course of action listed was to ensure all new PRN antipsychotic orders were accompanied by 14 day stop dates. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 7 days."	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 54 R22's Febuary Medication Administration Record (MAR) was reviewed 2/1/25 through 2/24/25 and identified R22 received PRN lorazepam daily and 12 of the 24 days had received the medication two to four times per day. R22 received the PRN olanzapine 14 times during that period. R22's medical record was reviewed and lacked evidence the consulting pharmacist's recommendation on R22's identified medication irregularities had been forwarded, reviewed and/or acted upon by the physician. During telephone interview on 2/27/25, at 12:54 p.m. the consulting pharmacist (CP)-E stated she had made a recommendation in January to make sure the provider completed a face to face evaluation and then every 14 days. When CP-E spoke with the DON she was told everything was addressed in January but during her review in February CP-E had to reissue her recommendations. That was when the DON discovered the recommendations had not been addressed by the provider. CP-E would have expected the provider to follow up on her recommendations within 7 days and they were not. When interviewed on 2/27/25, at 2:12 p.m. the DON stated she was aware antipsychotic and psychotropic medications needed to be evaluated within 14 days with a duration stop date and PRN antipsychotic medications needed to have a face to face provider evaluation.The DON was not sure what the facility's process was for obtaining the information needed to meet the requirement. The DON had given the pharmacist recommendations to another nurse to address with the physician she was not sure why they	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 55 were not addressed. The DON stated she needed to do a better job following up on the pharmacy recommendation with her nurses. During telephone interview on 2/27/25, at 3:29 p.m. R22's primary provider (DR)-A stated he was not aware a face to face evaluation was required every 14 days when prescribing PRN antipsychotic medications. He did know R22 was very aggressive and had attacked staff. MD-A saw R22 two times since his admission and the nurses never mentioned the regulation. MD-A did the medical rounds and the mental health practioner nurse practioner (NP)-F did the mental health rounds. NP-F would be more aware of the regulations regarding those medications. On 2/27/25, at 4:01 p.m. NP-F was called with a request for a return call, however, none was received. R36: R36's admission MDS dated 12/11/24, identified R36 had intact cognition and diagnoses included general anxiety disorder, depression, chronic pain and bipolar disorder. R36's Order Summary Report dated 2/27/27, included the current medication regimen with their corresponding start dates. This included orders for clonazepam 1 mg in the morning and 0.5 mg at bedtime, diazepam 5 mg every 24 hours as needed for anxiety, hydrocodone-acetaminophen 7.5-325 mg every 8 hours as needed and hydrocodone-acetaminophen 7.5-325 mg every 8 hours for pain. R36's completed Consultant Pharmacist's Medication Review, dated December 2024,	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 56 identified R36's medication regimen was reviewed and an irregularity was identified involving R36's medication diazepam with comment since the medication was used for a psychological condition and due to updated CMS regulations, the PRN medication had to be re-evaluated within the first 14 days of starting. If the medication was to be continued a re-evaluation date was needed. The suggested course of action listed was to add a re-evaluation date to re-assess, i.e., continue for 60 days then re-evaluate, etc. R36 was also taking another scheduled benzodiazepine, clonazepam two times per day. There was a potential for addictive effects and increased adverse reactions. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on "... ASAP [as soon as possible] but no later than 30 days." R36's completed Consultant Pharmacist's Medication Review, dated January 2024, identified R36's medication regimen was reviewed and an irregularity was lidentified involving R36's medication hydrocodone/acetaminophen with comment R36 was at increase risk for CNS/respiratory depression due to the combined use of a benzodiazepine and an opioid analgesic. Hydrocodone/acetaminophen and clonazepam. The suggested course of action listed recommended re-assessing the use of the combination of medications. Please provide clinical rationale, for documentation purposes, the the current benefits outweigh the risks. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on "... ASAP [as soon as	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21530	Continued From page 57 possible] but no later than 30 days." R36's medical record lacked evidence the consulting pharmacist's recommendation on R36's benzodiazepam and opioid medications had been forwarded, reviewed and/or acted upon by the physician. A policy was not received for pharmacy reviews. SUGGESTED METHOD OF CORRECTION: The DON or designee with the consulting pharmacist could review and revise policies and procedures identifying residents who have irregularities identified in their medication review; and ensure the DON, medical director and provider receive a copy; and ensure they are acted upon. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure the irregularities are identified and acted upon. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in	21535		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 58 part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure use of an as-needed psychotropic medication was limited to a 14-day period and/or re-evaluated by the provider to ensure ongoing need and efficacy of the medications for 2 of 5 residents (R18,R22) reviewed for unnecessary medication use. In addition, the facility failed to complete comprehensive assessment and ongoing monitoring of behaviors for an administered antipsychotic medication to ensure efficacy of the medication for 1 of 5 residents (R11) reviewed for unnecessary medication use. Findings include: R18: R18's significant change Minimum Data Set (MDS) dated 1/6/25, identified R18 had a severe cognitive impairment and diagnoses that included Alzheimer's disease and dementia. R18 did not exhibit behaviors during the assessment period.	21535	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 59 R18's undated care plan, identified R18 used anti-anxiety medications (lorazepam) related to recent changes in health status. Interventions included: - Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. - Make referrals for me as needed - Monitor me for safety. I am taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. - Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations - Monitor/record occurrence of for target behavior symptom, inappropriate response to verbal communication, violence/aggression towards staff/daughter and document per facility protocol. - My non-pharmacological interventions include: 1: 1, Distraction/redirection, family visits. - Observe for changes in my behavior and update provider R18's physician order dated 1/16/25, identified lorazepam tablet 0.5 milligram (MG). Give one tablet by mouth every two hours as needed for anxiety or agitation. R18's electronic medication administration record (EMAR) dated January 2025, identified R18 received lorazepam on 1/29/25.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 60 R18's EMAR dated February 2025, Jan EMAR identified R18 received lorazepam on 2/11/25 and 2/21/25. R18's medical record failed to identify if a a face-to-face provider evaluation for continued use of a as needed (PRN) psychotropic medication was completed. R18's nursing progress notes identified the following: - 1/16/25 at 2:27 p.m., R18 was slightly declining for the past 48 hours. Concerns were discussed with family. Orders were obtained from the medical director (MD) to ensure R18 remained comfortable and had no anxiety/anxiousness. Lorazepam 0.5mg every 2 hours as needed and morphine sulfate 20mg/milliliter (mL), give 0.125mL every 2 hours as needed for severe pain/discomfort, and oxygen to maintain sats above 90% or for comfort. These medications should only be utilized if/when R18 was no longer safe to obtain oral pain medications. - 1/29/25 at 6:10 p.m., R18 was in the dining room sitting at her daughter's table and started yelling "help me help me, I want to lay down". When approached, R18 started yelling that she needed to go to bed. Staff took R18 to her room and got her into her bed. R18 was not in her bed 10 minutes, and R18 began yelling that she wanted to get up. Staff got her up and then R18 started to say she wanted to lay down again. Staff would tell her that she needed to stay up for a while and that they could not keep laying her down and getting her back up. Staff was administered 0.5mg Ativan at 6:01 p.m. for anxiety. R18 was saying that her legs hurt, she did get her pain medication as scheduled at 5:50 p.m. R18 was sitting in the dining room and kept asking staff to lay her back down.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 61 - 2/11/25 at 3:58 p.m., R18 was lying in bed and started hollering "help me"," help me"!! When staff arrived, R18 was flailing her arms and legs around and starting to dry heave. Staff was unable to get R18 to calm down, staff administered 0.5mg Ativan at 3:46 p.m., a warm blanket and sat by her bedside until R18 calmed down and fell asleep. - 2/21/25 at 12:46 a.m., R18 was yelling out non-stop. R18 insisted that she was laying on top of a car and the guys have to get her off. Staff spent 1:1, changed her brief, gave fluids and offered a snack. Staff was unable to redirect/reorient her. She declined snack, took in fluids but continued to yell out. R18 was anxious and teary, very agitated. As needed lorazepam 0.5 mg was given. Staff continued to reassure R18 that everything was okay. During an interview on 2/27/25 at 12:55 p.m., registered nurse (RN)-F stated she recently learned an as needed antipsychotic should be re-evaluated with a face-to-face provider visit every two weeks. I just learned that yesterday. RN-F stated R18's medical record lacked information identifying a face-to-face provider evaluation was completed. During a phone interview on 2/27/25 at 3:29 p.m., R18's physician (DR)-A stated he was unaware of the requirement to perform a face-to-face re-evaluation of antipsychotic PRN medications every 14 days and nursing did not inform him. R11: R11's admission MDS dated 11/21/24, identified R11 had severe cognitive impairment and required moderate assistance with dressing, bathing, and toileting. R11 was identified to have	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 62 wandering one to three times during the assessment period and did not exhibit physical or verbal behaviors toward others. R11's diagnoses included malignant neoplasm of the rectal sigmoid junction and thrombocytopenia. R11's care plan with revision date 12/24/24, identified R11 was at risk for elopement and wandering. Interventions included to provide a wander guard and structured activities such as toileting, walking, and reorientation strategies such as signs, pictures, and memory boxes. Use of psychotropic medications related to behavior management was also identified. Staff were instructed to administer medications as ordered, monitor for side effects, discuss with physician regarding ongoing need and indicated R11 was on a behavior management program, however, lacked documentation of what behaviors were exhibited and/or what the behavior management program entailed. The care plan further identified R11 at risk for insomnia with interventions to administer medications as ordered, maintain a consistent routine to retire and wake up and discourage daytime naps. R11's Order Summary Report dated 2/17/25, identified an order for quetiapine 25 mg one tablet at bedtime related to dementia with other behavioral disturbances with order date 11/26/24, gabapentin 250 mg/5ml give 1 ml three times per day related to dementia with other behavioral disturbances with order date 1/22/25, and escitalopram 2.5 mg every morning related to dementia with other behavioral disturbances with order date 12/18/24. Staff were directed to monitor for side effects related to the psychotropic medications. Target behaviors with order date 11/29/24, listed depression with non-pharmalogical approaches of one to one,	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 63 distraction, calm approach and offer food/drink every shift. Staff were to record if behaviors had been observed or not observed. R11's Order Summary Report dated 2/26/25, identified R11's gabapentin was increased from 1 ml three times per day to 1.5 ml three times per day with start date 2/24/25. The medical record lacked an assessment to support the increase in gabapentin. R11's MAR for February 2025, identified the medication quetiapine, gabapentin and escitalopram was administered every day 2/1/24 through 2/26/25, as ordered. Target behaviors were not monitored on the February 2025, MAR. On 2/25/25, at 11:20 a.m. R11 was observed standing with walker in his room doorway, fully dressed in preparation to go to the dining area for lunch. When staff attempted to redirect R11 back into room, R11 stated no he did not want to eat in his room. R11 was assisted to put on a face mask and assisted to the dining area. R11 remained seated alone at the dining room table, removing his mask only to eat and then returned to his room. On 2/26/25, at 11:36 a.m. R11 was observed seated in a recliner in his room. R11 was seated quietly in his room. There was no television in room and/or magazines visible nearby. R11 watched as staff and residents passed by the room and occasionally would holler out a greeting and/or smile and wave. A joint interview was conducted on 2/27/25, at 9:13 a.m. with nursing assistant (NA)-A and NA-H. NA-A stated she was not aware R11 had any behaviors. R11 could sometimes act a little	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 64 grumpy or anxious but liked to joke around and would soon come out of it. R11 was a nice man but would at times get anxious if he had nothing to do. R11 always seemed to need something to do but once you found something to occupy him, he was fine. NA-H stated R11 was very nice and liked to read the paper in the dining area and people watch. R11 enjoyed visiting with others and staff frequently sat down with him to visit and he would laugh and joke with them. Never resistive or combative with cares or others. R11's progress notes, dated 1/28/25 to 2/24/25, were reviewed. A progress note dated 2/18/25, identified R11's mood was pleasant with no unwanted behaviors witnessed and R11 slept through the night. No behavioral incidents were recorded in the 28-day period reviewed. R11's medical record lacked evidence what symptoms or specific behaviors were being tracked or monitored to ensure the efficacy of the ordered quetiapine and gabapentin and support the use of the medications. During interview on 2/27/25, at 9:33 a.m. registered nurse (RN)-B stated R11 had dementia and experienced a lot of anxiety, but she never witnessed aggressive behaviors. The gabapentin was increased on 2/24/25, for R11's own comfort to see if they could make him feel better. R11 would wander and get very anxious and make comments that he did not know why he was here or what he should be doing. R11 seemed more comfortable now and less episodes of those behaviors happening. RN-B did not do rounds with the mental health provider NP-F and so was not sure what was discussed when NP-F increased R11's medication. R11's anxiety was not on the care plan, and it should have been. It	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 65 would be important to list the type of behavior R11 exhibited and the interventions so staff could utilize them before medication to decrease R11's symptoms of loneliness and depression. During telephone interview on 2/27/25, at 12:54 p.m. the consultant pharmacist (CP)-E stated R11 received quetiapine at bedtime for dementia and that was not an appropriate diagnosis for the medication unless there was evidence the behaviors could harm self or others. There were usually targeted behaviors and non pharmalogical interventions in the care plan related to the use of antipsychotic medications and she had noticed R11's care plan did not address behaviors. CP-E had also noted NP-F had increased R11's gabapentin in January and there was no rationale for the increase in R11's medical record. CP-E reviewed all the progress notes for behaviors as well and could not find rationale for the medication increase documented. During interview on 2/27/25, at 2:12 p.m. the DON stated she would expect anxiety and related behaviors to have been documented on R11's plan of care. She knew R11 had a lot of anxiety, and she would have expected some behavioral incidents to have been documented in his progress notes to justify the initiation and two increased doses of gabapentin ordered and/or whether the medication was successful or not. Dementia alone was not enough of a reason to prescribe quetiapine or gabapentin, and the DON needed to speak with the provider regarding the issue. During telephone interview on 2/27/25, at 3:29 a.m. with R22's primary physician (DR)-A stated he was not sure who had first prescribed quetiapine for R11, however, he thought he had	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 66 done the admission orders. The diagnoses just popped up on the chart and he picked the most appropriate diagnosis. DR-A was not aware of all the regulations and the issues had not been brought up to him when he conducted rounds at the facility. R11 was seen by a mental health provider NP-F and she would be more aware of all the regulations surrounding those type of medications. On 2/27/25, at 4:01 p.m. NP-F was called with a request for a return call; however, none was received. The facility policy Psychotropic Medications dated 8/20/24, identified the facility would have the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, behavioral interventions and psychopharmacological medications could be utilized to meet the needs of the individual resident. Primary providers would order psychotropic medication only for the treatment of specific medical and/or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by non-pharmacological approaches. The provider would document rationale and diagnosis for use and identify Target Behavior symptoms for the reason the medication was being utilized. PRN psychotropic medications ordered would be limited to 14 days. The prescribing practitioner would evaluate and document the medications necessity, benefits, and improvement (expressions, indications of distress). If the physician deemed it appropriate to extend beyond the 14-day limit, supporting rationale must be documented.	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21535	Continued From page 67 The facility staff would monitor and document for the presence of target behaviors daily, charting by exception (i.e., charting only when the behaviors are present), noting any adverse effects, review usage of the medications with the physician and the IDT on a quarterly basis to determine the continued presence of target behaviors and/or presence of any adverse effects, implement non-pharmacological interventions for target behavior(s), document results, and add to care plan, and utilize PRN psychotropic medication, following provider order, if non-pharmacological intervention(s) are unsuccessful. SUGGESTED METHOD OF CORRECTION: The DON or designee could review policies and procedures related to 14-day face to face visits and ensure non-pharm interventions are assessed and care planned to effectively monitor medication effectiveness. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure face to face visits occur every 14 days for PRN antipsychotics and ensure behaviors are monitored for effectiveness of the medication. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the	21942		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21942	Continued From page 68 council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council within the past calendar year as required. This deficient practice had the potential to affect all 38 residents who resided in the facility. Findings include: On 2/25/25 at 10:09 a.m., the activities director (AD) stated the facility did not have a family council, although families were told upon admission and care conferences that a meeting could be set up upon request. The AD stated she had not documented the invites and had not formulated a letter to be mailed to family representatives inviting them to a council meeting. On 2/26/25 at 3:25 p.m., activities director (AD) stated the last family council was scheduled for 5/18/22, however, there had not been a meeting and no further documented attempts to set up a family council since that time. Review of a letter addressed to "Family and Friends" dated 4/25/22, identified each resident and/or family member was given a brochure discussing family councils, then a yearly follow-up letter was to be sent again to inquire into interest in developing a family council. A letter for 2023 and 2024 was requested but not received.	21942	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	912 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) COMPLETE DATE
21942	Continued From page 69 The Resident Council and Family Council policy dated 8/1/21, identified the care center would encourage the formation of a Family Council. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee should delegate an individual to be responsible for the annual attempt to establish a family council. The administrator and/or designee should audit the delegate's efforts at forming a family council, and record when a meeting (if established) or attempts at establishing the family council occurred within each calendar year. Audits on the success or inability to form resident council should be taken to the QAPI committee for oversight to ensure compliance is achieved. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21942		