Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 24, 2025

Administrator
LITTLEFORK CARE CENTER
912 MAIN STREET
LITTLEFORK, MN 56653

RE: CCN: 245542
Cycle Start Date: August 6, 2025

Dear Administrator:

On November 14, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 19, 2025

Administrator
LITTLEFORK CARE CENTER
912 Main Street
Littlefork, MN 56653

RE: CCN:245542
Cycle Start Date: August 6, 2025

Dear Administrator:

On , August 6, 2025, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and

Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by November 6, 2025(three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 6, 2026(six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution

process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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September 19, 2025

Administrator
LITTLEFORK CARE CENTER
912 MAIN STREET
LITTLEFORK, MN 56653

Re: Event ID: **1D26ACH1**

Dear Administrator:

The above facility survey was completed on August 6, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	**912 MAIN STREET , LITTLEFORK, Minnesota, 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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/5/25 through 8/6/25 , a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaints were reviewed: H55421068C (2571036) Minnesota Department of Health is documenting the State	20000		09/24/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	**912 MAIN STREET , LITTLEFORK, Minnesota, 56653**

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20000	Continued from page 1 Licensing Correction Orders using Federal Software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		

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F0000	INITIAL COMMENTS On 8/5/25 through 8/6/25, 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 reviewedH55421068C (2571036). As a result of the survey, deficiencies cited at F609, F627. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		08/11/2025
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term	F0609	The Administrator and/or designee implemented corrective action for Residents R1 and R2 affected by this practice by ensuring that their abuse allegations were reported to the State Agency (SA) on 07/24/2025. Tracking ID: 361219. State regulations and company policies will be followed accordingly. All residents residing in the facility have the potential to be affected by this deficient practice. Administrator and/or designee will implement measures to ensure that this practice does not recur including: The facility's Maltreatment Reporting Guidelines policy was reviewed by the SFHS Clinical Nurse Consultant with no changes needed. On 08/11/2025, the Administrator and Interim Director of Nursing received education from the SFHS Clinical	10/06/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245542**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/06/2025**

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LITTLEFORK CARE CENTER	**912 MAIN STREET , LITTLEFORK, Minnesota, 56653**

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F0609 SS = D	Continued from page 1 care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure timely reporting of an allegation of resident to resident abuse to the state agency (SA) for 2 of 2 residents (R1, R2) reviewed for abuse. Findings include: R1's Admission Record indicated he admitted to the facility 1/10/25, with diagnosis that included neurocognitive disorder with lewey bodies, dementia with mood disturbance, agitation and psychotic disturbance. R1's quarterly Minimum Data Set (MDS) dated 6/11/25, identified severe cognitive impairment and indicated he displayed physical, verbal and other behaviors 1-3 days during the assessment period. The MDS indicated R1 ambulated independently. R1's care plan dated 5/22/25, identified a risk for harm to self or others. The care plan directed staff to approach R1 from the side when upset, hold hands gently when attempting to re-direct, and if he posed a potential threat to self or others, approach calmly and speak directly to him. The care plan further directed nursing to contact law enforcement to send to the emergency department (ED) when aggressive and not directable. R1's Progress Notes indicated the following: 7/22/25, At approximately 2:30 p.m., R1 was standing at the nurses station and had a friendly conversation with R2. R1 walked away, then turned back around and Grabbed onto R2's walker. R2 asked him to let go and R1 yelled at her and pushed R2 backwards. Before staff could interfere, R1 struck R2 in the chest. Staff assisted R2 to keep from falling and R1 continued to reach around and grabbed and punched at R2. R1 connected with R2's chest and shoulder at least three times.	F0609	Continued from page 1 Nurse Consultant on the facility's Maltreatment Reporting Guidelines policy, including who to report alleged maltreatment to, how to complete a report, and required timelines for reporting to the State Agency. All facility staff who would assist with reporting allegations of maltreatment to the State Agency will be educated on the facility's Maltreatment Reporting Guidelines policy, including requirements for timely reporting of maltreatment allegations. This includes Interim DON and Social Services Designee. Audits will be completed by the Administrator and/or designee on allegations of maltreatment of a vulnerable adult to ensure they were reported to the State Agency and reported timely per policy beginning the week of 9/29/25, 3x/week x 2 weeks, 2x/week x 2 weeks, and weekly thereafter. Audit findings will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee on a quarterly basis for further recommendations.	

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NAME OF PROVIDER OR SUPPLIER **LITTLEFORK CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **912 MAIN STREET , LITTLEFORK, Minnesota, 56653**	

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F0609 SS = D	Continued from page 2 R2's Admission Record indicated she admitted to the facility 3/14/24. Diagnosis included cerebral infarction (stroke), hyperlipidemia and hypertension. R2's quarterly MDS dated 6/4/25 indicated her short term memory was okay. The MDS indicated R2 displayed verbal and physical behaviors 1-3 days during the assessment period and indicated she ambulated independently. R2's Care Plan dated 4/9/25, identified a potential to be verbally aggressive related to poor impulse control and directed staff to guide away from source of distress. A facility incident report dated 7/22/25, indicated At approximately 2:30 p.m., R2 was standing at the nurses station. R1 was also standing there having a snack. R1 walked away, then turned back around and grabbed R2's walker. R2 very kindly asked him to let go and his behavior changed instantly. R1 yelled at R2 and pushed her back. Before staff could intervene, R1 struck R2 in the chest. Staff stepped between the two residents but R1 continued reaching around the staff and grabbed and punched at R2. The report indicated R2 sustained injury to her right shoulder and reported pain rated 7/10 to her right shoulder and neck. R2 also had a lump on the front of her right bicep. During interview on 8/8/25 at 12:45 p.m., the social service designee (SD) stated she had completed a report right away after the incident occurred but said she had not reported to the correct agency. During interview on 8/6/25 at 10:10 a.m., the administrator stated the incident had not been reported to the SA timely and said after the corporate consultant identified it had not been reported, she reported the incident to the SA. Facility policy Maltreatment Reporting Guidelines dated undated indicated if suspected maltreatment occurred, report to the SA immediately, but not later than 2 hours after the allegation is made if the incident involves abuse, neglect, or financial exploitation that results in serious bodily injury, including injuries of unknown source and misappropriation of VA property.	F0609		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)	F0627	On 07/22/2025, the Responsible Party for R1 was provided with notice of discharge by the Administrator. This discussion occurred in person with the daughter and husband, with the wife participating by telephone. The decision was reviewed in detail, and it was	10/06/2025

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F0627 SS = D	Continued from page 3 §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident	F0627	Continued from page 3 explained that R1's condition had progressively declined and that a higher level of care was necessary to address his needs and support his mental wellbeing. The family acknowledged and agreed with this plan of care. All residents have the potential to be affected by this practice. Administrator and/or designee will implement measures to ensure that this practice does not recur including: The Involuntary Discharge and Appeals Rights policy was reviewed by the Regional Director with no changes needed. On 9/25/25, the Administrator was educated by the Regional Director regarding the requirements of the Involuntary Discharge and Appeals Rights policy, including the obligation to provide a written notice of intent to discharge. No additional involuntary discharges have occurred since 7/22/25. Audits will be completed by the Administrator and/or designee on all involuntary discharges to ensure a written notice of intent to discharge was completed per policy beginning the week of 9/29/25, 3x/week x 2 weeks, 2x/week x 2 weeks, and weekly thereafter. Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245542	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	**912 MAIN STREET , LITTLEFORK, Minnesota, 56653**

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F0627 SS = D	Continued from page 4 under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and	F0627		

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LITTLEFORK CARE CENTER	**912 MAIN STREET , LITTLEFORK, Minnesota, 56653**

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F0627 SS = D	Continued from page 5 (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245542**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK CARE CENTER	**912 MAIN STREET , LITTLEFORK, Minnesota, 56653**

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F0627 SS = D	Continued from page 6 the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245542	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2025

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F0627 SS = D	Continued from page 7 (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to provide notice of intent to discharge for 1 of 1 residents (R1) who was sent to the hospital and discharged from the facility. Findings include: R1's Admission Record indicated he admitted to the facility 1/10/25, with diagnosis that included neurocognitive disorder with Lewey bodies, dementia with mood disturbance, agitation and psychotic disturbance. R1's quarterly Minimum Data Set dated 6/11/25, identified severe cognitive impairment and indicated he displayed physical, verbal and other behaviors 1-3 days during the assessment period. R1's care plan dated 5/22/25, identified a risk for harm to self or others. The care plan directed staff to approach R1 from the side when upset, hold hands gently when attempting to re-direct, and if he posed a potential threat to self or others, approach calmly and speak directly to him. The care plan further directed nursing to contact law enforcement to send to the emergency department (ED) when aggressive and not directable. R1's Progress Notes indicated the following: 7/22/25, At approximately 2:30 p.m., R1 was standing at the nurse's station and had a friendly conversation with R2. R1 walked away, then turned back around and Grabbed onto R2's walker. R2 asked him to let go and R1 yelled at her and pushed R2 backwards. Before staff could interfere, R1 struck R2 in the chest. Staff assisted R2 to keep from falling and R1 continued to reach around, grabbing and punching at R2. R1 connected with R2's chest and shoulder at least three times. R1 was taken to the emergency department.	F0627		

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F0627 SS = D	Continued from page 8 7/24/25, Facility staff received a phone call that R1 would be returning to the facility. Direction from facility administrator was to notify hospital not to accept R1 for re-admission. 7/25/25, R1 had been officially discharged from the facility and is being placed in a behavioral health unit. A facility incident report dated 7/22/25, indicated At approximately 2:30 p.m., R2 was standing at the nurses station. R1 was also standing there having a snack. R1 walked away, then turned back around and grabbed R2's walker. R2 very kindly asked him to let go and his behavior changed instantly. R1 yelled at R2 and pushed her back. Before staff could intervene, R1 struck R2 in the chest. Staff stepped between the two residents but R1 continued reaching around the staff and grabbed and punched at R2. The incident report indicated R1 was sent to the emergency department for placement elsewhere. During interview on 8/6/25 at 10:10 a.m., the administrator stated R1 was in a behavioral health unit and said the facility had discharged him due to his aggression. The administrator said when the hospital called and wanted to send him back to the hospital the facility did not take him back and said they did not have the resources to give him what he needed. The administrator stated they had discussed a memory care unit with R1's family but said she did not know what the families plan for R1 was. A facility discharge policy was requested but not received.	F0627		