DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 20, 2022

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: August 10, 2022

Dear Administrator:

On August 22, 2022, we notified you a remedy was imposed. On September 9, 2022 the Minnesota Department of Health 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 August 30, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 6, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 22, 2022, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 6, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 30, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office 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
Minnesota Department of Health
Licensing and Certification Program

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
August 22, 2022

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: August 10, 2022

Dear Administrator:

On August 10, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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 Region V Office for imposition. The CMS Region V Office 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 October 6, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 6, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 6, 2022.

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.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 $11,292; 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 October 6, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Littlefork Medical Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 6, 2022. 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 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 an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
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 - 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 February 10, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL 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 August 9-10, 2022, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H55423789C (MN00085658) with deficiencies cited at F583, F730 and F880. The following complaint was found to be UNSUBSTANTIATED: H55423794C (MN00085674) with no deficiencies issued. 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 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes	F 583		8/30/22

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

Electronically Signed | 08/30/2022

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

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F 583	Continued From page 1 accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident's dignity was maintained for 2 of 3 residents (R1, R3) who received personal care but were not provided personal privacy. Findings include: R1's annual Minimum Data Set (MDS) dated 6/30/22, indicated R1 was alert and orientated	F 583	1. R1 and R3 share a room. Nursing staff have all be re-educated on maintaining a resident’s dignity when providing cares to them. 2. All residents who have a roommate have the potential to be effected by the deficient practice. 3. DON or designee will educate all staff regarding resident cares and privacy. They will be instructed to provide the	

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F 583	Continued From page 2 and had diagnoses including psychosocial development disorder, depression and congestive heart failure. The assessment indicated R1 required extensive assistance with bed mobility, required total assistance with transfers, toileting and was always incontinent of bowel and bladder. R1's activities of daily living Care Area Assessment (CAA) dated 7/1/22, indicated R1 was physically unable to stand to bear weight and required the use of a full body mechanical lift for transfers. R1's care plan dated 3/1/22, directed the staff to assist with incontinence cares every two hours and to assist R1 with transferring via a full body mechanical lift. R3's significant change MDS dated 7/8/22, identified R3 had severe cognitive impairment and diagnoses of adult failure to thrive and involuntary movements. The assessment indicated R3 required extensive assistance with bed mobility, total assistance for transfers and incontinence cares. R3 was always incontinent of bowel and bladder. R3's activities of daily living CAA dated 6/15/22, indicated R3 was dependent upon staff for all activities of daily living. R3's care plan dated 8/2/22, directed the staff to check and change R3's incontinence products every two hours and to transfer R3 via a full body mechanical lift On 8/9/22, at 4:25 p.m. R1 was observed in bed. Nursing assistant (NA)-D and NA-F entered R1's room and assisted her with incontinence cares.	F 583	utmost privacy to each and every resident receiving treatment or cares. 4. Random observational audits for appropriate privacy measures will be completed by DON or designee 3x/week x 2 weeks, then once weekly thereafter for a total of six months. Auditing will begin on 8/30/22. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for 684 is 8/30/22. Review: Dignity Policy	

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F 583	Continued From page 3 R1's roommate (R3) was observed resting in a second bed in the room. During the incontinent cares, NA-D and NA-F were not observed to close the privacy curtain. R1's naked bottom was in full view of R3 during the cares. On 8/9/22, at 4:29 p.m. NA-D and NA-F assisted R3 with incontinence cares. R3's roommate (R1) was observed to be in the room. The NAs were not observed to pull the privacy curtain between the two residents while perineal cares were provided. R3's naked bottom was exposed to R1 during the cares. Once the cares were completed, R1 was transferred from the bed to a wheelchair via a full body mechanical lift. On 8/9/22, at 4:42 p.m. NA-D confirmed the privacy curtain had remained open while providing cares to R1 and R3. NA-D stated the curtain should have been pulled to provide privacy for both residents to ensure their personal privacy and dignity. On 8/10/22, at 9:34 a.m. R1 was wheeled into her room by NA-D and NA-E. R1's roommate (R3) was observed to be in her bed as NA-D and NA-E assisted R1 to transfer from the wheelchair to the bed via a full body mechanical lift. NA-D and NA-E were not observed to pull the privacy curtain between the two residents during the transfer. Once in bed, NA-D and NA-E were observed to check R1's incontinence brief. R1 was incontinent of bowel. The NAs assisted R1 with perineal care and applied a fresh incontinent brief. R1's naked bottom was in full view of R3. Once the fresh incontinent brief was in place, NA-D pulled the privacy curtain between R1 and R3.	F 583		

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F 583	Continued From page 4 On 8/10/22, at 12:56 p.m. the director of nurses (DON) stated the privacy curtain was to be pulled between residents while personal cares were being performed. The DON confirmed R3 had limited cognitive skills, but she would still expect the staff members to maintain privacy for all residents during personal cares. The Dignity policy dated 10/23/17, directed the staff to treat each individual resident residing in the facility with respect and dignity and to ensure the cares were provided in a manner that promoted, maintained, or enhanced the quality of life for each resident. The policy specifically directed the staff to promote, maintain and protect resident privacy, including bodily privacy during assistance with personal cares.	F 583		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance evaluations for 2 of 5 nursing assistants (NA-E, NA-A) who had been employed by the facility for over one year. Findings include: NA-E was hired on 3/20/20. NA-E's personnel	F 730	1. Nurse Aides NA-A and NA-E requiring a performance review have been completed. 2. All Nurse aids who work here have the potential to be effected by deficient practice. 3. All Nurse aids will receive a performance review within 60 days of their anniversary date of employment. Human	8/30/22

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F 730	Continued From page 5 record indicated the last performance evaluation was completed on 5/12/21. NA-A was hired on 4/17/21. NA-A's personnel record indicated the last performance evaluation was completed on 5/19/21. On 8/10/22, at 3:10 p.m. the administrator stated the facility had not been able to keep up with performance evaluations. The administrator confirmed the performance evaluations were to be completed annually, however, NA-E and NA-A's evaluations had not been completed timely. The Employee Recruitment, Selection, Hiring and Retention policy dated 10/20/20, directed the facility to complete annual performance evaluations for all employees to discuss an employee's achievements, strengths and further opportunities for growth and success.	F 730	Resource assistant will provide a monthly list to the Director of Nursing and Administrator at the beginning of each month. These performance reviews will be completed within that time period. 4. Random observational audits will be completed by HR/Administrator to ensure that DON or designee completed all performance reviews within their window per the Employee Recruitment, Selection, Hiring and Retention policy and will complete the audits 2x month, then once monthly for six months. Auditing began on 8/30/22. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 5. Completion date for F686 is 8/30/22. Review: Employee Recruitment, Selection, Hiring and Retention Policy	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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.	F 880		8/30/22

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F 880	Continued From page 6 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 §483.70(e) 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 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	F 880		

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F 880	Continued From page 7 (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 ensure mechanical lifts were disinfected between resident use to decrease the potential spread of infection for 3 of 3 residents (R1, R2, R3) observed to be transferred via a full body mechanical lift. Residents had their own slings but residents touched the bars and connection sections on the lift during the transfer. Findings include: R1's annual Minimum Data Set (MDS) dated 6/30/22, indicated R1 was alert and orientated and had diagnoses including psychosocial development disorder, depression and congestive heart failure. The assessment indicated R1 required total assistance with transfers and was unable to ambulate. R1's care plan dated 3/1/22, directed the staff to assist R1 with transfers via a full body mechanical	F 880	DIRECTED PLAN OF CARE: Equipment/Environment: 1. R1,R2 and R3 are current residents in the facility. Staff have undergone retraining on how to clean shared equipment. Signs have been placed on equipment to remind staff to clean in between residents. 2. All residents who utilize mechanical lifts have the potential to be effected by this deficient practice. 3. On 8/23/22, the facility's Quality Assurance and Performance Improvement Committee met to conduct a root cause analysis to identify the problems that resulted in this deficiency and developed interventions or corrective action plan to prevent reoccurrence. 4. Training has been completed by DON or designee for all staff responsible for resident care equipment and environment on the facility policies/procedures for	

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	245542	A. BUILDING _____ B. WING _____	C 08/10/2022

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F 880	Continued From page 8 lift. R2's quarterly MDS dated 7/6/22 and annual MDS dated 1/10/22, identified R2 with severe cognitive impairment and diagnoses including dementia, anxiety and depression. The MDS indicated R2 required total assistance with transfers and was unable to ambulate. R2's care plan dated 3/8/22, directed the staff to transfer R2 with a full body mechanical lift. R3's significant change MDS dated 7/8/22, identified R3 with severe cognitive impairment and diagnoses of adult failure to thrive and involuntary movements. The assessment indicated R3 required total assistance with transfers and was unable to ambulate. R3's care plan dated 2/25/22, directed the staff to transfer R3 with a full body mechanical lift. On 8/9/22 at 4:22 p.m. nursing assistant (NA)-D and NA-F assisted R1 to transfer from bed to a wheelchair. Once in the chair, NA-D wheeled the lift out into the hallway and placed next to the wall. A black bag containing a box of "purple top" sanitizing wipes was observed to be attached to the lift. At no time was NA-D observed to disinfect the lift. On 8/9/22, at 4:36 p.m. NA-D and NA-F transferred R3 from her bed to a wheelchair via the full body mechanical lift. Once in the chair, the staff were not observed to disinfect the lift. On 8/9/22, at 4:42 p.m. NA-D stated the lifts were to be wiped off with the sanitizing wipes after each use. NA-D pointed to the container of wipes	F 880	proper disinfection, including following manufacturer direction for use. Each staff member will demonstrate competency at the conclusion of training. 5. The DON or designee are conducting audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, and then 3x week for two weeks and, then once weekly for six months. Auditing began on August 25, 2022. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. The monitoring results will be reported monthly to the Quality Assurance Committee and quarterly to the QAPI team. The QAPI team will make recommendations for ongoing monitoring. 6. Completion date for F880 is August 30, 2022. Review: Cleaning, Disinfecting Resident Care Equipment Policy	

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F 880	Continued From page 9 attached to the lift and stated, "the wipes are right there, I just forgot." NA-D then removed a wipe and wiped off the lift. On 8/10/22, at 7:09 a.m. NA-D was observed to push a full body mechanical lift out of a room across from R1's room. NA-D was not observed to attempt to disinfect the lift as she maneuvered the lift into R1's room. NA-D and NA-E connected the lift to R1 and transferred R1 from the bed to the chair. At no time did the staff attempt to disinfect the lift as NA-E wheeled the lift into the hallway. On 8/10/22, at 7:39 a.m. NA-D and NA-E assisted R2 with morning cares. Once the cares were complete, NA-E exited the room and returned with the full body mechanical lift. The NAs transferred R2 from the bed to a wheelchair via the full body lift. Once in the chair, NA-D wheeled the lift out of the room. At no time was she observed to attempt to disinfect the lift. On 8/10/22, at 8:42 a.m. NA-D and NA-E were observed to transfer R3 from the wheelchair back to bed via the full body mechanical lift. On 8/10/22, at 8:45 a.m. NA-D stated, "Oh yeah, we need to clean the lift." NA-D removed a sanitizer wipe from the container and began to disinfect the lift. NA-D confirmed she had not disinfected the lift between R1 and R2 during morning cares or prior to assisting R3. NA-D stated, "I just always forget to do that." On 8/10/22 at 12:53 p.m. the director of nurses (DON) stated each lift had a container of sanitizing wipes connected to them to ensure all staff disinfected the lifts after use. The DON	F 880		

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F 880	Continued From page 10 stated all staff members had received training on disinfecting the lifts and were aware of the facility policy. The Cleaning/Disinfecting Resident Care Equipment policy dated 6/5/17, indicated the mechanical lifts were to be cleaned after each use, the areas coming into contact with the resident during care will be disinfected (e.g., handles, arms knee pads, foot rests.). The entire lift was to be cleaned on a routine basis by the housekeeping staff members.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2022

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

Re: Event ID: NW0011

Dear Administrator:

The above facility survey was completed on August 10, 2022 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 08/10/2022

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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 8/9/22 - 8/10/22, 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 complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H55423789C (MN00085658) with no order issued. The following complaint was found to be UNSUBSTANTIATED: H55423794C (MN00085674) with no order issued. Minnesota Department of Health is documenting the State 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.	2 000		