DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 20, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: January 23, 2025

Dear Administrator:

On February 19, 2025, the Minnesota Departments of Health and Public Safety, 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

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 20, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

Re: Reinspection Results
Event ID: 778612

Dear Administrator:

On February 19, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 23, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 30, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: January 23, 2025

Dear Administrator:

On January 23, 2025, 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 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 April 23, 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 July 23, 2025 (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

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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 01/23/2025

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 1/23/25, 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 complaints were reviewed: H55424001C (MN109526), H55425860C (MN109578) with deficiencies cited at F585, F609, F610. 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		2/17/25

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

Electronically Signed | 01/31/2025

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 01/23/2025

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 585	Continued From page 1 §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations	F 585		

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 01/23/2025

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 585	Continued From page 2	F 585		

by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than

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 01/23/2025

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 585	Continued From page 3 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to act on grievance filed for 1 of 3 residents (R1) reviewed who filed a grievance alleging verbal abuse by staff. Findings include: R1's Admission Record indicated she admitted to the facility on 3/18/24. R1's diagnosis included cerebral palsy, post-traumatic stress disorder, bipolar disorder, and anxiety. R1's quarterly Minimum Data Set (MDS) dated 12/19/24, identified intact cognition and indicted she displayed verbal behaviors during the assessment period. The MDS indicated R1 was dependent on staff for toileting and transfers. R1's care plan dated 12/11/24, identified a behavior problem; requesting task from staff, then refusing when staff attempt to provide. The care plan always directed two staff in R1's room and indicated R1 was either elated or upset, would yell with cares, make false accusations of abuse by staff, and wanted instant gratification. The care plan directed staff to discuss behavior if reasonable, leave her alone to calm down when yelling at staff and validate feelings. A Grievance Report dated 12/21/24, written by R1 indicated she had been verbally abused by a staff member two or more times. During interview on 1/23/25 at 12:44 p.m., the social services designee (SSD) stated when R1	F 585	R1 grievance was investigated by the State Agency on 1/23/25. All residents within the facility could potentially be impacted by this deficient practice. Reporting Grievance policy was reviewed by the DON on 1/24/25 with no changes needed. Social Services Designee was educated on the Reporting Grievance policy by the Director of Nursing on 1/31/2025, including resident's right to file a grievance or complaint, grievance policy, informing residents of their rights to file and grievance and providing them a copy of the policy if requested, providing the resident with a written decision after the investigation of a grievance, immediate actions to be taken during an investigation to ensure residents' safety and prevent additional violations, Social Services Designee and/or designee will audit all grievances to ensure Reporting Grievance policy and process was followed, 2x/week x 4weeks, then weekly thereafter starting 1/31/2025. Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	

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 01/23/2025

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 585	Continued From page 4 filed the grievance she had reached out to R1's family member (FM). The SSD stated the grievance was never filed because the FM told her not to even though R1 was her own decision maker and had filed the grievance. The SSD stated typically if a resident had a concern, they would ask them if they wanted to file a formal grievance and would then give the report to the DON and the administrator. The SSD stated the grievance was never turned into the administrator but said the concerns were reported to the DON. During interview on 1/23/25 at 2:16 p.m. the administrator stated if a grievance was filed in writing he expected the grievance to be responded to in writing. Facility policy Reporting a Grievance dated 1/9/17, indicated if a grievance is voiced by an individual or an individual's responsible party, the care center will make prompt efforts to investigate and resolve the grievance. The policy indicated the grievance officer was responsible for issuing grievance decisions to the resident. The policy indicated grievances would be investigated within 72 hours. Documentation should include the steps taken to investigate the grievance, a summary of pertinent conclusions, a statement as to whether the grievance was substantiated or not and the date the written conclusion was issued.	F 585		
F 609 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	F 609		2/17/25

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 01/23/2025

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 609	Continued From page 5 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 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 immediately report an allegation of abuse to the state agency, but no later than two hours, for 1 of 3 residents (R1) reviewed who alleged abuse from staff in the facility. Findings include: R1's Admission Record indicated she admitted to the facility on 3/18/24. R1's diagnosis included cerebral palsy, post-traumatic stress disorder, bipolar disorder, and anxiety. R1's quarterly Minimum Data Set (MDS) dated	F 609	R1 verbal abuse allegation was investigated by the State Agency on 1/23/25. All residents within the facility could potentially be impacted by this deficient practice. Maltreatment Reporting Guidelines policy was reviewed by the SFHS Quality Nurse Consultant on 1/24/25 with no changes needed. All allegations of abuse will be reported to the State Agency according to Maltreatment Reporting Guidelines policy. Director of Nursing was educated on 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 01/23/2025

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 609	Continued From page 6 12/19/24, identified intact cognition and indicted she displayed verbal behaviors during the assessment period. The MDS indicated R1 was dependent on staff for toileting and transfers. R1's care plan dated 12/11/24, identified a behavior problem; requesting task from staff, then refusing when staff attempt to provide. The care plan always directed two staff in R1's room and indicated R1 was either elated or upset, would yell with cares, make false accusations of abuse by staff, and wanted instant gratification. The care plan directed staff to discuss behavior if reasonable, leave her alone to calm down when yelling at staff and validate feelings. R1's Progress Notes identified the following: 12/27/24, R1 asked staff to make copies of a 6-7 page letter she had written to the administrator. Staff member made copies and gave the administrators copy to the registered nurse on duty. 12/31/24, The director of nursing (DON) was given a note from staff, written by this resident. In the note it stated multiple complaints about staff neglecting, abusing, and ignoring her. R1 had a history of accusing staff of those things. R1's family member was made aware of behaviors and stated R1 tended to get like that around the holidays. R1 had made statements to staff on multiple occasions "it's all about me". Staff were interviewed and on this specific occasion stated R1 was upset because a staff member did not return to help her with cares when she said she would. 1/8/25. R1 had multiple complaints and stated	F 609	Maltreatment Reporting Guidelines policy by the SFHS Quality Nurse Consultant on 1/24/25. All nursing staff will be educated on the Maltreatment Reporting Guidelines policy by the DON and/or designee. DON and/or designee will audit all alleged abuse complaints to ensure that they have been reported to the State Agency following care center Maltreatment Reporting Guidelines policy, 2x/week x 4weeks, then weekly thereafter starting 1/31/2025. Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	

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 01/23/2025

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 609	Continued From page 7	F 609		

she had hoped to discuss her concerns with the social services designee (SSD) and the administrator. R1 state she had written a letter to the administrator, hoping he would come and talk to her, but it had not happened.

A letter dated 12/26/25, written by R1 to the administrator indicated she had been emotionally abused by almost all the staff on the p.m. shift. R1 also wrote, she did not feel she should have to put up with staff members "intentional neglect" and wrote she felt forgotten and felt the staff was purposely neglecting her. R1 further wrote in the letter, "Who can I talk to about this p.m. shift abuse?"

A Grievance Report dated 12/21/24, written by R1, indicated a nursing assistant (NA) "verbally abused me twice or more."

During interview on 1/23/25 at 12:06 a.m., R1 stated one of the staff members (NA-A) verbally abused her so she did not allow NA-A into her room because she did not want to be "triggered." R1 stated she felt helpless and said, "what do you do when someone treats you that way?" R1 further stated she had written a letter to the DON and the administrator and said they never responded.

During interview on 1/23/25 at 1:01 p.m. the DON stated the allegations were not reported to the SA because her care plan indicated a history of false accusations, so she did not feel there was really any neglect. The DON stated the administrator was made aware of the allegations and did not feel it was reportable.

During interview on 1/23/25 at 2:16 p.m., 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 01/23/2025

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 609	Continued From page 8 administrator stated when resident reports abuse the facility did an internal review to determine if the allegations were reportable to the SA. The administrator said if a resident had a history of making similar complaints the allegations would not be reportable. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, indicated care center must report to the SA any suspected maltreatment (all alleged violations involving abuse, neglect, financial exploitation or maltreatment, including injuries of unknown source and misappropriation of resident property) 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.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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	F 610		2/17/25

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 01/23/2025

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 610	Continued From page 9 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 investigate an allegation of abuse for 1 of 3 residents (R1) reviewed when R1 reported an allegation of abuse. Findings include: R1's Admission Record indicated she admitted to the facility on 3/18/24. R1's diagnosis included cerebral palsy, post-traumatic stress disorder, bipolar disorder, and anxiety. R1's quarterly Minimum Data Set (MDS) dated 12/19/24, identified intact cognition and indicted she displayed verbal behaviors during the assessment period. The MDS indicated R1 was dependent on staff for toileting and transfers. R1's care plan dated 12/11/24, identified a behavior problem; requesting task from staff, then refusing when staff attempted to provide. The care plan directed two staff at all times in R1's room and indicated R1 was either elated or upset, would yell with cares, make false accusations of abuse by staff, and wanted instant gratification. The care plan directed staff to discuss behavior if reasonable, leave her alone to calm down when yelling at staff and validate feelings. R1's Progress Notes identified the following: 12/27/24, R1 asked staff to make copies of a 6-7 page letter she had written to the administrator. Staff member made copies and gave the	F 610	R1 verbal abuse allegation was investigated by the State Agency on 1/23/25. All residents within the facility could potentially be impacted by this deficient practice. Maltreatment Reporting Guidelines policy was reviewed by the SFHS Quality Nurse Consultant on 1/24/25 with no changes needed. All allegations of abuse will be investigated according to Maltreatment Reporting Guidelines policy. Director of Nursing was educated on the Maltreatment Reporting Guidelines policy by the SFHS Quality Nurse Consultant on 1/24/25. All nursing staff will be educated on the Maltreatment Reporting Guidelines policy by the DON and/or designee. DON and/or designee will audit all alleged abuse complaints to ensure that they were investigated following care center Maltreatment Reporting Guidelines policy, 2x/week x 4weeks, then weekly thereafter starting 1/31/2025. Audit results will be brought to the QAPI committee quarterly for review and further recommendations.	

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 01/23/2025

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 610	Continued From page 10	F 610		

administrators copy to the registered nurse on duty.

12/31/24, The director of nursing (DON) was given a note from staff, written by this resident. In the note it stated multiple complaints about staff neglecting, abusing, and ignoring her. R1 had a history of accusing staff of those things. R1's family member was made aware of behaviors and stated R1 tended to get like that around the holidays. R1 had made statements to staff on multiple occasions "it's all about me". Staff were interviewed and on this specific occasion stated R1 was upset because a staff member did not return to help her with cares when she said she would.

1/8/25. R1 had multiple complaints and stated she had hoped to discuss her concerns with the social services designee (SSD) and the administrator. R1 state she had written a letter to the administrator, hoping he would come and talk to her, but it had not happened.

A letter dated 12/26/25, written by R1 to the administrator indicated she had been emotionally abused by almost all the staff on the p.m. shift. R1 also wrote, she did not feel she should have to put up with staff members "intentional neglect" and wrote she felt forgotten and felt the staff was purposely neglecting her. R1 further wrote in the letter, "Who can I talk to about this p.m. shift abuse?"

A Grievance Report dated 12/21/24, completed by R1 indicated a nursing assistant (NA) "verbally abused me twice or more."

During interview on 1/23/25 at 12:06 a.m., R1

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 01/23/2025

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 610	Continued From page 11 stated one of the staff members (NA-A) verbally abused her so she did not allow NA-A into her room because she did not want to be "triggered." R1 stated NA-A came into her room after a 45-minute wait and said she asked NA-A, "what if I was having a heart attack." R1 stated NA-A replied and said, "I know you; you wouldn't be having a heart attack." R1 stated she felt helpless and said, "what do you do when someone treats you that way?" R1 further stated she had written a letter to the DON and the administrator and said they never responded. During interview on 1/23/25 at 1:01 p.m. the DON stated, regarding R1's allegations of abuse, she had multiple conversation with staff and with R1 but was unable to provide evidence of an investigation. During interview on 1/23/25 at 2:16 p.m., the administrator stated he would expect a thorough investigation including interviews with other residents. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, indicated within five working days of submitting the initial report to the MDH/OHFC the reporter must submit a completed copy of the investigation to the SA.	F 610		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 30, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

Re: State Nursing Home Licensing Orders
Event ID: 778611

Dear Administrator:

The above facility was surveyed on January 23, 2025 through January 23, 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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 _____	01/23/2025

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 1/23/25 , 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 and	2 000		

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

Electronically Signed | 01/31/25

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 _____	01/23/2025

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: H55424001C (MN109526), H55425860C (MN109578) with a licensing orders issued at 1880 and 1980. 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	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 _____	01/23/2025

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 not required at the bottom of the first page of 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		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an	21880		2/17/25

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 _____	01/23/2025

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
21880	Continued From page 3 advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to act on grievance filed for 1 of 3 residents (R1) reviewed who filed a grievance alleging verbal abuse by staff. Findings include: R1's Admission Record indicated she admitted to the facility on 3/18/24. R1's diagnosis included cerebral palsy, post-traumatic stress disorder, bipolar disorder, and anxiety. R1's quarterly Minimum Data Set (MDS) dated 12/19/24, identified intact cognition and indicted she displayed verbal behaviors during the assessment period. The MDS indicated R1 was dependent on staff for toileting and transfers. R1's care plan dated 12/11/24, identified a behavior problem; requesting task from staff, then refusing when staff attempt to provide. The care plan always directed two staff in R1's room and	21880	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 _____	01/23/2025

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
21880	Continued From page 4 indicated R1 was either elated or upset, would yell with cares, make false accusations of abuse by staff, and wanted instant gratification. The care plan directed staff to discuss behavior if reasonable, leave her alone to calm down when yelling at staff and validate feelings. A Grievance Report dated 12/21/24, written by R1 indicated she had been verbally abused by a staff member two or more times. During interview on 1/23/25 at 12:44 p.m., the social services designee (SSD) stated when R1 filed the grievance she had reached out to R1's family member (FM). The SSD stated the grievance was never filed because the FM told her not to even though R1 was her own decision maker and had filed the grievance. The SSD stated typically if a resident had a concern, they would ask them if they wanted to file a formal grievance and would then give the report to the DON and the administrator. The SSD stated the grievance was never turned into the administrator but said the concerns were reported to the DON. During interview on 1/23/25 at 2:16 p.m. the administrator stated if a grievance was filed in writing he expected the grievance to be responded to in writing. Facility policy Reporting a Grievance dated 1/9/17, indicated if a grievance is voiced by an individual or an individual's responsible party, the care center will make prompt efforts to investigate and resolve the grievance. The policy indicated the grievance officer was responsible for issuing grievance decisions to the resident. The policy indicated grievances would be investigated within 72 hours. Documentation should include the steps taken to investigate the grievance, a	21880		

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 _____	01/23/2025

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
21880	Continued From page 5 summary of pertinent conclusions, a statement as to whether the grievance was substantiated or not and the date the written conclusion was issued. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to grievances to ensure grievances are acted upon and the resident given a resolution to the identified grievance. The director of nursing, social worker, or designee could develop a system to educate staff and develop a monitoring system such as measurable audits to ensure grievances are acted upon and the resolution notification is made to the resident and/or family. The results of those audits could be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from	21980		2/17/25

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 _____	01/23/2025

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
21980	Continued From page 6 another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to immediately report an allegation of abuse to the state agency, but no later than two	21980	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 _____	01/23/2025

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
21980	Continued From page 7 hours, for 1 of 3 residents (R1) reviewed who alleged abuse from staff in the facility. Findings include: R1's Admission Record indicated she admitted to the facility on 3/18/24. R1's diagnosis included cerebral palsy, post-traumatic stress disorder, bipolar disorder, and anxiety. R1's quarterly Minimum Data Set (MDS) dated 12/19/24, identified intact cognition and indicted she displayed verbal behaviors during the assessment period. The MDS indicated R1 was dependent on staff for toileting and transfers. R1's care plan dated 12/11/24, identified a behavior problem; requesting task from staff, then refusing when staff attempt to provide. The care plan always directed two staff in R1's room and indicated R1 was either elated or upset, would yell with cares, make false accusations of abuse by staff, and wanted instant gratification. The care plan directed staff to discuss behavior if reasonable, leave her alone to calm down when yelling at staff and validate feelings. R1's Progress Notes identified the following: 12/27/24, R1 asked staff to make copies of a 6-7 page letter she had written to the administrator. Staff member made copies and gave the administrators copy to the registered nurse on duty. 12/31/24, The director of nursing (DON) was given a note from staff, written by this resident. In the note it stated multiple complaints about staff neglecting, abusing, and ignoring her. R1 had a history of accusing staff of those things. R1's	21980		

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 _____	01/23/2025

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
21980	Continued From page 8 family member was made aware of behaviors and stated R1 tended to get like that around the holidays. R1 had made statements to staff on multiple occasions "it's all about me". Staff were interviewed and on this specific occasion stated R1 was upset because a staff member did not return to help her with cares when she said she would. 1/8/25. R1 had multiple complaints and stated she had hoped to discuss her concerns with the social services designee (SSD) and the administrator. R1 state she had written a letter to the administrator, hoping he would come and talk to her, but it had not happened. A letter dated 12/26/25, written by R1 to the administrator indicated she had been emotionally abused by almost all the staff on the p.m. shift. R1 also wrote, she did not feel she should have to put up with staff members "intentional neglect" and wrote she felt forgotten and felt the staff was purposely neglecting her. R1 further wrote in the letter, "Who can I talk to about this p.m. shift abuse?" A Grievance Report dated 12/21/24, written by R1, indicated a nursing assistant (NA) "verbally abused me twice or more." During interview on 1/23/25 at 12:06 a.m., R1 stated one of the staff members (NA-A) verbally abused her so she did not allow NA-A into her room because she did not want to be "triggered." R1 stated she felt helpless and said, "what do you do when someone treats you that way?" R1 further stated she had written a letter to the DON and the administrator and said they never responded.	21980		

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 _____	01/23/2025

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
21980	Continued From page 9 During interview on 1/23/25 at 1:01 p.m. the DON stated the allegations were not reported to the SA because her care plan indicated a history of false accusations, so she did not feel there was really any neglect. The DON stated the administrator was made aware of the allegations and did not feel it was reportable. During interview on 1/23/25 at 2:16 p.m., the administrator stated when resident reports abuse the facility did an internal review to determine if the allegations were reportable to the SA. The administrator said if a resident had a history of making similar complaints the allegations would not be reportable. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, indicated care center must report to the SA any suspected maltreatment (all alleged violations involving abuse, neglect, financial exploitation or maltreatment, including injuries of unknown source and misappropriation of resident property) 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. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility could re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits could be taken to the Quality Assurance Performance Improvement	21980		

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 _____	01/23/2025

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
21980	Continued From page 10 (QAPI) committee to determine the need for further monitoring or compliance. Those audits could be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		