DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 25, 2025

Administrator
LITTLEFORK CARE CENTER
912 MAIN STREET
LITTLEFORK, MN 56653

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 4, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

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

Dear Administrator:

On February 20, 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 May 20, 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 August 20, 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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 02/20/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/19/25 through 2/20/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H55426481C (MN00110302), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to perform a comprehensive assessment of falls to include	F 689	R2 has had no additional falls since 2/11/25. A wider bed was ordered for R2 on 3/10/25. RN Case Manager to update	3/31/25

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

Electronically Signed | 03/10/2025

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

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

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F 689	Continued From page 2	F 689		

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

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

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

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

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

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

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

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

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

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 4, 2025

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

Re: State Nursing Home Licensing Orders
Event ID: NCV111

Dear Administrator:

The above facility was surveyed on February 19, 2025 through February 20, 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
Federal Enforcement | Health Regulation Division
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 _____	C 02/20/2025

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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 2/19/25 through 2/20/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed: H55426481C (MN00110302) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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

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2 000	Continued From page 2 state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to perform a comprehensive assessment of falls to include root cause and failed to implement appropriate interventions to reduce the risk for falls from bed for 1 of 3 residents (R2) reviewed who had multiple falls from bed. Findings include: R2's Admission Record indicated he admitted to	2 830	corrected	3/31/25

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

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

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

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

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