Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 5, 2023

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: February 16, 2023

Dear Administrator:

On February 28, 2023, we notified you a remedy was imposed. On March 27, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 20, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 15, 2023 be discontinued as of March 20, 2023. (42 CFR 488.417 (b))

In our letter of February 28, 2023, 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 15, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 5, 2023

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

Re: Reinspection Results
Event ID: 1T5V12

Dear Administrator:

On March 27, 2023 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 February 16, 2023. 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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
February 28, 2023

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: February 16, 2023

Dear Administrator:

On February 16, 2023, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 15, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 15, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 15, 2023.

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 15, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Littlefork Medical Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 15, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 16, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/15/2023-2/16/2023, 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. H55428282C (MN00090817) with a deficiency issued at F609, F656, and 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 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 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	F 609		3/20/23

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

Electronically Signed | 03/09/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1 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, within two hours, report an allegation of neglect resulting in serious physical injury for one of eight residents (R1) reviewed when R1 was dropped from a mechanical lift resulting in a laceration to her left posterior scalp, requiring three staples at the emergency room. Findings include: Minimum Data Set (MDS) assessment, dated 1/18/2023, indicated R1's diagnoses included Alzheimer's disease, dementia, psychotic disorder, and non-traumatic brain dysfunction. R1's Brief Interview for Mental Status (BIMS) score was 2 out of 15 indicating sever cognitive impairment. R1's service/care plan dated 2/26/22 indicated R1 was dependent with transfers using a Hoyer	F 609	A facility must report abuse immediately, but no later that 2 hours, and report an injury of unknown source no later than 24 hours. R1 was transferred with a Hoyer lift, toilet sling and 1 staff. She moved her arms and slipped out of the sling to the floor and sustained and injury. The incident report was done on 2/4 at 3:40pm and it was reported to the State Agency on 2/4 at 10:25pm. This report time was past the 2-hour requirement. R1 has not had a fall since this incident. She is now being transferred with a medium full back lift sling and Hoyer. The staff involved was re-educated on the timeframes of reporting to the State Agency. All staff will have re-education and training on the Maltreatment Policy and Maltreatment Reporting Guidelines. All residents have the potential to have	

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 mechanical lift with a sling and the assistance of two staff. R1's progress note dated 2/4/2023 indicated R1 suddenly moved her arms while in the sling and slipped out of the sling falling to the floor. R1 landed on her head, sustained a laceration. R1 was transferred to the hospital. R1's Fall Scene Investigation dated 2/4/2023 indicated R1's fall occurred on 2/4/2023 at 3:40 p.m. R1 fell from the mechanical lift when she brought her arms inside the toileting sling and slipped through the bottom of the sling. A facility document titled Koochiching Health Services Teachable Moment, dated 2/5/2023 at 11:20 a.m., indicated RN-A did not notify administration appropriately to comply with incident reporting timeframes. A facility report to the State Agency indicated for the fall from the mechanical lift was submitted incident by the DON at 2/4/2023 at 10:25 p.m. During an interview on 2/15/2023 at 2:30 p.m., nursing assistant (NA)-A stated she does not remember the exact time she entered R1's room to transfer her to the toilet. NA-A stated R1 was lying in her bed with a toileting sling of unknown size underneath her. NA-A stated she connected the toileting sling beneath R1 to the mechanical lift and transferred R1 to the toilet without the assistance of another staff member. NA-A stated while transferring R1 from the toilet to the bed, R1 shifted her weight and fell through the opening of the sling and onto the ground. NA-A stated she called for assistance, and support staff provided additional medical care until emergency services	F 609	this happen to them. The DON or designee will train the charge nurses and nurse managers on how to do a report on the OHFC website. That way they can do the initial report within the 2 hour or 24 hour time frame. The DON or designee will monitor incident reports and reporting times 3x/week for 4 weeks, 2x/week for 4 weeks, and 1x/week for 4 weeks and then weekly thereafter. The monitoring results will be brought to QAPI for recommendations for ongoing monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 arrived. During an interview on 2/15/2023 at 4:40 p.m., the Director of Nursing (DON) stated she was informed of R1's accident via text message from RN-A sometime in the afternoon. The DON stated she arrived at the facility the evening of 2/4/2023 to question staff and report the incident. The DON stated part of their corrective action was to complete a written correction for RN-A for her failure to appropriately notify administration of the accident. The DON stated she did not report the incident to the state agency until the night of 2/4/2023. A facility policy titled Accidents/Incidents, dated 4/6/2015, indicated if a reportable incident occurs, the facility must immediately report the incident to the state agency.	F 609		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		3/20/23

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 4 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to update resident care plans for five of eight residents (R1, R3, R4, R5, and R8) to determine appropriate sling size and type used by facility staff while transferring with a mechanical lift. Findings include:	F 656	R1, R3, R5, and R8 care plans were all updated with the sling size that they use when transferring with the Hoyer Lift. R4 passed away on 2/18/23. All residents who utilize a mechanical lift have the potential for this to happen to them. The DON or designee will look through and update the residents care plan with the appropriate sling size.	

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 5 A facility document titled Lifts, updated on 2/15/2023 indicated residents R1, R3, R4, R5, R6, R7, and R8 are dependent on mechanical lifts for transfer. Minimum Data Set (MDS) assessment dated 1/18/2023 indicated R1's diagnoses included Alzheimer's disease, dementia, psychotic disorder, and non-traumatic brain dysfunction. R1's functional mobility indicated she was dependent on staff for transfer and repositioning. R1's Brief Interview for Mental Status (BIMS) score was 2 out of 15 indicating sever cognitive impairment. R1's service/care plan dated 2/26/2022 indicated R1 was dependent with transfers using a Hoyer mechanical lift with a sling and the assistance of two staff. R1's medical record did not include a mechanical lift assessment, sling size, and type to transfer R1 or a Therapy to Nursing Communication. MDS assessment dated 1/24/2023, indicated R3's diagnoses included age-related physical debility and generalized muscle weakness. R3's functional mobility indicated R3 relies on substantial to maximal assistance from staff when transferring and repositioning. R3's BIMS score was 3 out of 15. R3's service/care plan dated 2/27/2022 indicated R3 transfers with the use of a Sara Stedy, a sit to stand lift, with the assistance of one or two staff. Staff were to monitor R3 for changes in transferability. R3's medical record did not include a mechanical	F 656	The Mechanical Lift policy was updated to reflect that the sling size needs to be in the care plan and then scheduled to the care stream for the nursing staff to know what sling size is needed for transfers. The DON or designee will educate all staff on policy change and where to find the residents sling size. The DON or designee will perform audits on residents care plans to ensure that sling size is care planned. This will be done 3x/week for 4 weeks, 2x/week for 4 weeks, 1x/week for 4 weeks and then monthly thereafter. Audit results will be brought to QAPI for further recommendations and monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 6 lift assessment, sling size, and type to transfer R3 or a Therapy to Nursing Communication. During an observation on 2/15/2023 at 1:18 p.m., R3 was transferred out of her wheelchair by trained medication aide (TMA)-A and nursing assistant (NA)-C using a mechanical lift. NA-C stated R3 was sitting on a medium size, full back sling. NA-C and TMA-A then use the medium full-back sling to transfer R3 from her wheelchair to her bed. At 1:27 p.m., TMA-A indicated the sling size and type could be viewed on R3's care plan; however, TMA-A could not locate where the sling size and type on R3's care plan. MDS assessment dated 1/13/2023 indicated R4's diagnoses included displaced intertrochanteric fracture of left femur, dementia, and anemia. R4's functional mobility indicated R4 relies on substantial to maximal assistance from staff when transferring and repositioning. R4's BIMS score was 5 out of 15 indicating severe impairment. R4's service/care plan dated 2/28/2022 indicated R4 transfers with the assist of two staff with using a Hoyer lift for all transfers. R4's medical record did not include a mechanical lift assessment, sling size, and type to transfer R4 or a Therapy to Nursing Communication. MDS assessment, dated 11/17/2022 indicated R5's diagnoses included neurogenic bladder, anemia, and other neurological conditions. R5's function mobility indicated R5 is dependent on staff for when transferring and repositioning. R5's service/care plan dated 2/26/2022 indicated	F 656		

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 7 R5 needed the assistance of two staff to transfer with a Hoyer lift. R5's medical record did not include a mechanical lift assessment, sling size, and type to transfer R5 or a Therapy to Nursing Communication. MDS assessment dated 1/26/2023 indicated R8's diagnoses included medically complex conditions, pneumonia, and edema. R8's functional mobility indicated R8 is dependent on staff for repositioning and transferring. R8's BIMS score was 3 out of 15 indicating severe impairment. R8's service/care plan dated 3/1/2022 indicated R8 transfers with the assist of two staff using a Hoyer lift. R8 required cuing before and during the transfer. R8's medical record did not include a mechanical lift assessment, sling size, and type to transfer R8 or a Therapy to Nursing Communication. During an interview on 2/15/2023 at 9:20 a.m., NA-D stated she determines how to provide care for residents based on their care plan. NA-D stated she reviews the care plan to determine if a resident needs to transfer with a mechanical lift. NA-D stated residents have resident specific slings which are determined by physical therapy (PT). NA-D stated she has not received training on how to determine which sling size and type is appropriate for patients. During an interview on 2/15/2023 at 1:10 p.m., TMA-A stated she determines how to provide direct patient care by referencing the care plans. TMA-A stated the care plans detail which sling type and size to use during transfers with the	F 656		

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 mechanical lifts. During an interview on 2/15/2023 at 1:30 p.m., NA-C stated she verifies the size and type of sling being used on the resident prior to operating the mechanical lift. NA-C stated the details of a resident's sling are listed in their care plans. NA-C stated she knows most of the resident's sling specifications due to her experience at the facility. During an interview on 2/15/2023 at 2:30 p.m., NA-A stated she references the care plan to determine how to transfer residents. NA-A indicated all information regarding the sling size and type needed to complete a transfer is listed in the care plan. NA-A stated it is common practice for facility staff to reference patient care plans to provide care. During an interview on 2/15/2023 at 2:35 p.m., registered nurse (RN)-B stated residents are assessed for the need for mechanical lifts upon admission. RN-B stated care plans are updated by registered nurses as changes in condition and needs develop. RN-B stated PT completes all assessments needed when changes in a resident's transferability occur. RN-B stated a form is completed by PT, a copy is given to the RNs and NAs on shift, and the care plan is updated by the RNs accordingly. RN-B indicated the sling size and type for a resident who transfers with a mechanical lift should be detailed in their care plan. RN-B stated if she needed to find out how a resident transfers, she would reference their care plan. During an interview on 2/15/2023 at 4:40 p.m., the Director of Nursing (DON) stated sling size and type should be detailed in the care plan for	F 656		

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9 any resident requiring a mechanical lift. The DON stated PT completes the assessments for sling size and type, and it is added to the care plan by the RNs. The DON indicated her expectations for staff is to reference the care plan when they are providing care. The DON stated if the sling specifications are not detailed in the care plan, she does not know how the staff know how to safely transfer a resident using the mechanical lift. During an interview on 2/16/2023 at 8:45 a.m., PT-A stated sling size is determined by weight and certain physical measurements obtained by the PT during their assessment. PT-A stated sling type is determined by the combined cognitive and physical abilities of the resident. PT-A stated once the assessment indicating a resident's sling size and type are provided to the nursing staff, it is the responsibility of the RN to update the resident's care plan. These assessments are communicated on a form titled Therapy to Nursing Communication. During an interview on 2/16/2023 at 9:15 a.m., RN-A stated PT will complete a resident's transfer assessment and deliver a Therapy to Nursing Communication to the RN desk. RN-A indicated once the resident's care plan has been updated, the original assessment is filed in the appropriate chart. RN-A stated there is no designated area RNs put the Therapy to Nursing Communication forms that have or have not been adapted to the care plan. RN-B is unable to provide an answer as to why a resident's care plan would not include the sling size or type. RN-A stated this is not usually an issue as most of the facility's NA's have memorized which residents use which slings.	F 656		

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10 During an interview on 2/16/2023 at 12:45 p.m., RN-A stated staff know which sling to use for which resident by referencing the care plan. According to the manufacturer instructions for the Volaro Series 4 Lift PC450/HD450, the section entitled Volaro Lift Slings instructs users how to select the sling type based on the physical attributes and capabilities of the resident. The section entitled Safe Working Loads instructs users to determine the appropriate size sling by referencing their chart detailing the resident's weight and bodily dimension requirements for each size sling. The section entitled Volaro PC450/HD450 General Procedure Guide for Training instructs operators to ensure the proper sling size has been selected prior to transferring a patient. A facility policy titled "Care Planning", dated 10/23/2017, states it is the responsibility of nursing or an otherwise appointed designee to update a resident's plan of care to reflect the assessments from each medical discipline. The document states the plan of care will be updated at all times and be changed on an as needed basis by nursing staff.	F 656		
F 689 SS=G	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	F 689		3/20/23

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of one resident (R1) remained free of an avoidable accident and injury when R1 was transferred by one staff with an improper sling on a mechanical lift operated by one staff member. R1 was dropped from a mechanical lift resulting in a laceration to her left posterior scalp, requiring three staples at the emergency room. Findings include: Minimum Data Set (MDS) assessment, dated 1/18/2023, indicated R1's diagnoses included Alzheimer's disease, dementia, psychotic disorder, and non-traumatic brain dysfunction. R1's functional mobility indicated she was dependent on staff for transfer and repositioning. R1's Brief Interview for Mental Status (BIMS) score was 2 out of 15 indicating sever cognitive impairment. R1's service/care plan dated 2/26/22 indicated R1 was dependent with transfers using a Hoyer mechanical lift with a sling and the assistance of two staff. R1's medical record did not include a mechanical lift assessment, sling size, and type to transfer R1 or a Therapy to Nursing Communication. R1's progress note dated 2/4/2023 indicated R1 suddenly moved her arms while in the sling and slipped out of the sling falling to the floor. R1 landed on her head, sustained a laceration. R1 was transferred to the hospital.	F 689	R1 will be reassessed by Therapy in the Mechanical Lift to ensure that the right lift and sling is used with the correct amount of assistance. R1 care plan and care stream will be updated with current/correct lift needs. This could affect all residents that utilize lifts. Therapy will screen all residents that utilize lifts to ensure that the lift in use is correct and safe for the resident. The care plan and care stream will be updated with any changes. All nursing staff will be reeducated on safety with mechanical lift transfers and what lift to utilize for each resident, the amount of assistance needed, and sling size. The DON or designee will perform lift/transfer audits to ensure that all transfers are done safely and according to the care plan. Audits will be done 3x/week for 4 weeks, 2x/week for 4 weeks, and then 1x/week for 4 weeks. Audit results will be brought to the QAPI Committee for recommendations for further monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 R1's Fall Scene Investigation, dated 2/4/2023 indicated R1 fell from the mechanical lift when she brought her arms inside the toileting sling and slipped through the bottom of the sling. A facility document titled Total Mechanical Lifts dated 2/6/2023 indicated for staff to please read and sign. The document read: "All total floor lifts are to be used with 2 people when transferring residents. There should be no exception to this. Basic Care Aides (BCAs) should not be running to controls but can be the second person while operating the lifts. The second person is to be guiding the resident and ensuring the process is running smoothly. If a lift sling or lift is not working appropriately for a resident, inform a licensed staff member (RN or LPN) of this immediately." During an interview on 2/15/2023 at 2:30 p.m., nursing assistant (NA)-A stated she entered R1's room to transfer her to the toilet using the mechanical lift. NA-A stated R1 was lying in her bed with a toileting sling of unknown size underneath her. NA-A stated she was familiar with R1 and recognized R1 did not normally transfer with a toilet sling. NA-A stated she connected the toileting sling underneath R1 to the mechanical lift and transferred her to the toilet without the assistance of another staff member. NA-A indicated she was aware a mechanical lift should be operated with at least two staff members. NA-A stated she did not seek out another staff member for assistance because she knew NA-B was busy. NA-A said while transferring R1 from the toilet back to bed, R1 shifted her weight, fell through the opening at the bottom of the toileting sling and struck her head.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 NA-A stated she called for assistance, and support staff provided additional medical care until emergency services arrived. During an interview on 2/15/2023 at 3:05 p.m., NA-B stated she was not with NA-A when R1 fell from the mechanical lift. NA-B stated she exited the resident rooms she had been in when she heard yelling and was told by NA-A to retrieve a nurse and call 911 for R1. NA-B stated she secured additional support staff and medical aid was issued to R1 while emergency services were contacted. NA-B stated NA-A approached her when they were alone and requested NA-B report she had been with NA-A when R1 fell from the mechanical lift. During an interview on 2/15/2023 at 3:43 p.m., the manufacturing representative for the mechanical lifts stated the toileting sling is rarely used because facilities usually use a sit and stand device for brining residents to and from the toilet, making falls from toileting slings rare. The representative stated it is possible for a resident without enough upper body strength to be placed in a toileting sling, retract their arms, and fall through the bottom. The style and size of sling needs to be determined by licensed individuals to make an assessment, the wrong sling size and style can easily result in a fall. During an interview on 2/15/2023 at 4:40 p.m., the director of nursing (DON) stated R1 was scheduled to be seen the next business day by physical therapy (PT) for a complete assessment for the size and type of sling to be used while transferring in a mechanical lift. The DON stated at the time of the fall, R1's care plan did not include the sling size or type to be used with the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 mechanical lift. The DON stated she expects staff to have at least two lift operators in the room while transferring residents with a mechanical lift. During an interview on 2/16/2023 at 8:45 a.m., PT-A stated sling size is determined by weight and certain physical measurements obtained by the PT during their assessment. PT-A stated sling type is determined by the combined cognitive and physical abilities of the resident. PT-A stated a toileting sling should only be used by residents with enough upper body strength to keep their arms around the outside of the sling while transferring. PT-A stated a full-back sling is appropriate for patients that have limited upper body strength or lack the cognition to follow simple instructions. According to the manufacturer instructions for the Volaro Series 4 Lift PC450/HD450, the section titled Volaro Lift Slings instructs users how to select the sling type based on the physical attributes and capabilities of the resident. The section entitled Safe Working Loads instructs users to determine the appropriate size sling by referencing their chart detailing the resident's weight and bodily dimension requirements for each size sling. The section entitled Volaro PC450/HD450 General Procedure Guide for Training instructs operators to ensure the proper sling size has been selected prior to transferring a patient. The manufacture instructions include a General Procedural Guide for Training recommended that everyone be in-services by the manufacturer's in-service video before operating and a copy of the training and check off list be kept in personnel records. The training list includes but is not limited to having an assistant to assist with the transfer, make sure the correct	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 sling and size is being applied, inspect the sling for damage, ensuring the battery is charged, the lift legs are positioned correctly, and the sling is secured to the lift applied appropriately. A facility policy titled "Care Planning", dated 10/23/2017, states it is the responsibility of nursing or an otherwise appointed designee to update a resident's plan of care to reflect the assessments from each medical discipline. The document states the plan of care will be updated at all times and be changed on an as needed basis by nursing staff.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2023

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

Re: State Nursing Home Licensing Orders
Event ID: 1T5V11

Dear Administrator:

The above facility was surveyed on February 15, 2023 through February 16, 2023 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, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
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 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/15/2023-2/16/2023, 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 order were issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00324	A. BUILDING: _____ B. WING _____	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed. H55428282C (MN00090817) with a licensing order issued at 0560. 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 state form.	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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to update resident care plans for five of eight residents (R1, R3, R4, R5, and R8) to determine appropriate sling size and type used by facility staff while transferring with a mechanical lift. Findings include: A facility document titled Lifts, updated on 2/15/2023 indicated residents R1, R3, R4, R5, R6, R7, and R8 are dependent on mechanical lifts for transfer. Minimum Data Set (MDS) assessment dated 1/18/2023 indicated R1's diagnoses included	2 560	Corrected	3/20/23

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 3 Alzheimer's disease, dementia, psychotic disorder, and non-traumatic brain dysfunction. R1's functional mobility indicated she was dependent on staff for transfer and repositioning. R1's Brief Interview for Mental Status (BIMS) score was 2 out of 15 indicating sever cognitive impairment. R1's service/care plan dated 2/26/2022 indicated R1 was dependent with transfers using a Hoyer mechanical lift with a sling and the assistance of two staff. R1's medical record did not include a mechanical lift assessment, sling size, and type to transfer R1 or a Therapy to Nursing Communication. MDS assessment dated 1/24/2023, indicated R3's diagnoses included age-related physical debility and generalized muscle weakness. R3's functional mobility indicated R3 relies on substantial to maximal assistance from staff when transferring and repositioning. R3's BIMS score was 3 out of 15. R3's service/care plan dated 2/27/2022 indicated R3 transfers with the use of a Sara Stedy, a sit to stand lift, with the assistance of one or two staff. Staff were to monitor R3 for changes in transferability. R3's medical record did not include a mechanical lift assessment, sling size, and type to transfer R3 or a Therapy to Nursing Communication. During an observation on 2/15/2023 at 1:18 p.m., R3 was transferred out of her wheelchair by trained medication aide (TMA)-A and nursing assistant (NA)-C using a mechanical lift. NA-C stated R3 was sitting on a medium size, full back	2 560		

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 4 sling. NA-C and TMA-A then use the medium full-back sling to transfer R3 from her wheelchair to her bed. At 1:27 p.m., TMA-A indicated the sling size and type could be viewed on R3's care plan; however, TMA-A could not locate where the sling size and type on R3's care plan. MDS assessment dated 1/13/2023 indicated R4's diagnoses included displaced intertrochanteric fracture of left femur, dementia, and anemia. R4's functional mobility indicated R4 relies on substantial to maximal assistance from staff when transferring and repositioning. R4's BIMS score was 5 out of 15 indicating severe impairment. R4's service/care plan dated 2/28/2022 indicated R4 transfers with the assist of two staff with using a Hoyer lift for all transfers. R4's medical record did not include a mechanical lift assessment, sling size, and type to transfer R4 or a Therapy to Nursing Communication. MDS assessment, dated 11/17/2022 indicated R5's diagnoses included neurogenic bladder, anemia, and other neurological conditions. R5's function mobility indicated R5 is dependent on staff for when transferring and repositioning. R5's service/care plan dated 2/26/2022 indicated R5 needed the assistance of two staff to transfer with a Hoyer lift. R5's medical record did not include a mechanical lift assessment, sling size, and type to transfer R5 or a Therapy to Nursing Communication. MDS assessment dated 1/26/2023 indicated R8's diagnoses included medically complex conditions,	2 560		

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 5 pneumonia, and edema. R8's functional mobility indicated R8 is dependent on staff for repositioning and transferring. R8's BIMS score was 3 out of 15 indicating severe impairment. R8's service/care plan dated 3/1/2022 indicated R8 transfers with the assist of two staff using a Hoyer lift. R8 required cuing before and during the transfer. R8's medical record did not include a mechanical lift assessment, sling size, and type to transfer R8 or a Therapy to Nursing Communication. During an interview on 2/15/2023 at 9:20 a.m., NA-D stated she determines how to provide care for residents based on their care plan. NA-D stated she reviews the care plan to determine if a resident needs to transfer with a mechanical lift. NA-D stated residents have resident specific slings which are determined by physical therapy (PT). NA-D stated she has not received training on how to determine which sling size and type is appropriate for patients. During an interview on 2/15/2023 at 1:10 p.m., TMA-A stated she determines how to provide direct patient care by referencing the care plans. TMA-A stated the care plans detail which sling type and size to use during transfers with the mechanical lifts. During an interview on 2/15/2023 at 1:30 p.m., NA-C stated she verifies the size and type of sling being used on the resident prior to operating the mechanical lift. NA-C stated the details of a resident's sling are listed in their care plans. NA-C stated she knows most of the resident's sling specifications due to her experience at the facility.	2 560		

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 6 During an interview on 2/15/2023 at 2:30 p.m., NA-A stated she references the care plan to determine how to transfer residents. NA-A indicated all information regarding the sling size and type needed to complete a transfer is listed in the care plan. NA-A stated it is common practice for facility staff to reference patient care plans to provide care. During an interview on 2/15/2023 at 2:35 p.m., registered nurse (RN)-B stated residents are assessed for the need for mechanical lifts upon admission. RN-B stated care plans are updated by registered nurses as changes in condition and needs develop. RN-B stated PT completes all assessments needed when changes in a resident's transferability occur. RN-B stated a form is completed by PT, a copy is given to the RNs and NAs on shift, and the care plan is updated by the RNs accordingly. RN-B indicated the sling size and type for a resident who transfers with a mechanical lift should be detailed in their care plan. RN-B stated if she needed to find out how a resident transfers, she would reference their care plan. During an interview on 2/15/2023 at 4:40 p.m., the Director of Nursing (DON) stated sling size and type should be detailed in the care plan for any resident requiring a mechanical lift. The DON stated PT completes the assessments for sling size and type, and it is added to the care plan by the RNs. The DON indicated her expectations for staff is to reference the care plan when they are providing care. The DON stated if the sling specifications are not detailed in the care plan, she does not know how the staff know how to safely transfer a resident using the mechanical lift.	2 560		

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 7 During an interview on 2/16/2023 at 8:45 a.m., PT-A stated sling size is determined by weight and certain physical measurements obtained by the PT during their assessment. PT-A stated sling type is determined by the combined cognitive and physical abilities of the resident. PT-A stated once the assessment indicating a resident's sling size and type are provided to the nursing staff, it is the responsibility of the RN to update the resident's care plan. These assessments are communicated on a form titled Therapy to Nursing Communication. During an interview on 2/16/2023 at 9:15 a.m., RN-A stated PT will complete a resident's transfer assessment and deliver a Therapy to Nursing Communication to the RN desk. RN-A indicated once the resident's care plan has been updated, the original assessment is filed in the appropriate chart. RN-A stated there is no designated area RNs put the Therapy to Nursing Communication forms that have or have not been adapted to the care plan. RN-B is unable to provide an answer as to why a resident's care plan would not include the sling size or type. RN-A stated this is not usually an issue as most of the facility's NA's have memorized which residents use which slings. During an interview on 2/16/2023 at 12:45 p.m., RN-A stated staff know which sling to use for which resident by referencing the care plan. According to the manufacturer instructions for the Volaro Series 4 Lift PC450/HD450, the section entitled Volaro Lift Slings instructs users how to select the sling type based on the physical attributes and capabilities of the resident. The section entitled Safe Working Loads instructs users to determine the appropriate size sling by	2 560		

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 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	Continued From page 8 referencing their chart detailing the resident's weight and bodily dimension requirements for each size sling. The section entitled Volaro PC450/HD450 General Procedure Guide for Training instructs operators to ensure the proper sling size has been selected prior to transferring a patient. A facility policy titled "Care Planning", dated 10/23/2017, states it is the responsibility of nursing or an otherwise appointed designee to update a resident's plan of care to reflect the assessments from each medical discipline. The document states the plan of care will be updated at all times and be changed on an as needed basis by nursing staff. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 560		