



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 8, 2024

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

RE: CCN: 245542
Cycle Start Date: September 26, 2024

Dear Administrator:

On September 26, 2024, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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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

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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 December 26, 2024 (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 March 26, 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) / 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/lrc_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.

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a small dot above the 'i' in Downing.

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

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

PRINTED: 10/16/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245542	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2024
NAME OF PROVIDER OR SUPPLIER LITTLEFORK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 9/25/24 through 9/26/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55428013C (MN00106547 and H55428416C (MN00106736) 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 comprehensively assess for removing and placing a Wander Guard	F 689	1. On 9/26/24 and on 10/8/24 an Elopement Risk Assessment was completed for R1 by the RN.	11/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/10/2024

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	<p>Continued From page 1</p> <p>(WG- alarming device) and ensure the fenced in area for residents was secure for 1 of 3 residents (R1) reviewed for resident safety.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 7/9/24, identified R1 had moderate cognitive impairment, wandering behaviors occurred daily, verbally expresses needs to staff, independent with walking, wander/elopement alarm was used daily.</p> <p>R1's elopement risk assessment dated 7/8/24, indicated R1 was at risk for wandering/elopement from facility. Wander guard (WG) was in place.</p> <p>R1's care plan dated 7/11/24, identified R1 being at risk for elopement due to cognitive status as he was exit seeking, wander guard was placed and regular facility checks were to be completed.</p> <p>A report to the State Agency (SA) dated 9/17/24, indicated on 9/17/24, staff received an alert from a citizen R1 was walking outside on the facility grounds. R1 refused to return to the facility, staff walked with R1 until he was calm and ready to return.</p> <p>The facility 5 day report dated 9/24/24, indicated actions taken as a result of an investigation and included: staff educated on changes made to R1 care plan, Wander Guard (WG- alert system) placed, all door alarms and WG checked to ensure proper functioning, staff educated on the WG policy and need for assessment when placing and need for assessment when placing or removing a WG, educated staff on who has a WG and who should be accompanied when going</p>	F 689	<p>On 9/26/24 a lock was placed to secure the gait in the fenced in area by ESD. A back-up alarm was also placed by ESD on the gait in the fenced area to alert staff if the gait does open.</p> <p>2.All residents who are at risk for elopement have the potential to be affected by the same deficient practice.</p> <p>3.The Elopement Policy was reviewed by DON and no changes needed.</p> <p>All residents at risk for elopement will be reviewed to ensure they have an Elopement Risk Assessment completed by the DON and/or designee per our Elopement Policy.</p> <p>All RN Case Managers will be educated on the Elopement Policy regarding when to complete an Elopement Risk Assessment by the DON and/or designee.</p> <p>All staff will be educated by the DON and/or designee that the lock on the gait in the fenced area is to be always locked. Education will also include that there is a back-up alarm in place on the gait in the fenced area to alert staff if the gait does open. The alarm is plugged in the East Hallway.</p> <p>4.DON and/or designee will complete random audits on Elopement Risk Assessments being completed per our Elopement Policy 3x/week x2 weeks, 2x/week x 2 weeks, and 1x/week x 2 weeks, then once weekly thereafter beginning 10/14/24.</p> <p>ESD and/or designee will complete random audits that the gait in the fenced in area is locked and back-up alarm in place 3x/week x2 weeks, 2x/week x 2 weeks, and 1x/week x 2 weeks, then once</p>	

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F 689	<p>Continued From page 2</p> <p>outside for safety purposes. No systemic issues found, and no other recent elopements had occurred.</p> <p>R1's progress note dated 9/17/24 at 12:19 p.m., indicated a visitor told staff he saw R1 leaving the gated area. When staff went to check on R1, R1 was walking through the adjoining lawn out to the roadway. Staff called the front desk to alert staff and two other staff came and approached R1 to return back to the facility.</p> <p>During observation on 9/25/24 at 2:48 p.m., R1 was outside sitting in a chair in a fenced in area on the East side of the facility. R1's chair was placed in front of the door which is mostly glass and R1 was easily supervised by staff. R1's Wander Guard was in place. The gate attached to the fence was secured by a bungee cord and a latch that was not locked.</p> <p>During interview on 9/25/24 at 2:52 p.m. nursing assistant (NA)-A stated R1 was able to be outside and was instructed to stay in front of the glass door so staff could supervise him, "we check on him all the time." NA-A stated when staff cannot see R1 through the door they are to check the fence area to complete a visual check. NA-A was not aware if there were changes to the fenced area since R1 exited the fenced area; NA-A observed the bungee cord and latch on the gate and stated those had been there since R1 admission to the facility.</p> <p>During interview on 9/26/24 at 10:33 a.m. designated social worker (DSW) stated R1 was admitted to the facility and a WG was placed on R1 as he was an elopement risk. On 8/12/24, the WG was removed per families request as R1 had</p>	F 689	<p>weekly thereafter beginning 10/14/24. Audit results will be brought to the QAPI committee quarterly for review and further recommendation.</p>	

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F 689	<p>Continued From page 3</p> <p>not attempted to elope. DSW was not aware if an assessment was completed prior to removing the WG. DSW confirmed R1 left the secured fenced area on 9/17/24.</p> <p>R1's medical record lacked an elopement risk assessment for removing the WG on 8/12/24, to ensure it was safe to remove the wanderguard. Further, the medical record lacked an elopement assessment for placing the WG back on after elopement incident on 9/17/24.</p> <p>During interview on 9/26/24 at 1:02 p.m., director of nursing (DON) stated there was not an elopement assessment completed to remove the WG or after the recent incident of leaving of the building and it should have been completed. The DON did not identify why the 5-day investigative report identified elopement assessment had been completed. DON confirmed the gate in the fence area had no changes and continued to use the bungee cord and latch on the gate since elopement. DON further stated staff were to keep doing frequent checks while R1 was outside and R1 was to sit in front of the door so staff can visually see R1.</p> <p>During phone call interview on 9/26/24 at 1:03 p.m. witness stated R1 was outside in the fenced area and was agitated and witness tried to distract R1 as he was wanting to leave. Witness said when R1 would not listen to not leave the area the witness then alerted staff. Witness recalled R1 was trying to use the fence gate to get out of the fenced area.</p> <p>During interview, via phone, on 9/26/24 at 2:14 p.m., case manager (CM) stated R1 left the building on 9/17/24 and did not have a WG at that</p>	F 689		

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F 689	<p>Continued From page 4</p> <p>time. CM stated family was contacted about trying to remove the WG and they agreed, CM did not recall an elopement assessment was completed when the WG was removed. CM stated the WG was removed due to "not feeling there was a concern R1 would leave."</p> <p>During phone call interview on 9/26/24 at 2:37 p.m., family member (FM) stated she was aware R1 had eloped and the WG was put back on after this incident. FM stated she was notified when the facility wanted to try to remove the WG because R1 had not attempted to leave the facility.</p> <p>The facility policy Elopement dated 8/1/22, indicated all resident will be assessed on admission for risk of wondering or elopement. At any time, a resident is identified at risk for elopement, an elopement assessment will be completed, and a plan put into place.</p>	F 689		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 8, 2024

Administrator
Littlefork Care Center
912 Main Street
Littlefork, MN 56653

Re: State Nursing Home Licensing Orders
Event ID: C6Q711

Dear Administrator:

The above facility was surveyed on September 25, 2024 through September 26, 2024 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.

Littlefork Care Center

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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

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00324	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/26/2024
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NAME OF PROVIDER OR SUPPLIER LITTLEFORK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 912 MAIN STREET LITTLEFORK, MN 56653
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 9/25/24 through 9/26/24 , 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</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/10/24
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Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>and identify the date when they will be completed.</p> <p>The following complaints were reviewed: H55428013C (MN00106547) and H55428416C (MN00106736) with a licensing order issued at 0830</p> <p>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.</p> <p>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</p>	2 000		

Minnesota Department of Health

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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 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		