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	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Littlefork Care Center	912 Main Street Littlefork, MN 56653

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on interview and document review the facility failed to act on grievance filed for 1 of 3 residents (R1) reviewed who filed a grievance alleging verbal abuse by staff. Findings include: R1's Admission Record indicated she admitted to the facility on [DATE]. R1's diagnosis included cerebral palsy, post-traumatic stress disorder, bipolar disorder, and anxiety. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicted she displayed verbal behaviors during the assessment period. The MDS indicated R1 was dependent on staff for toileting and transfers. R1's care plan dated 12/11/24, identified a behavior problem; requesting task from staff, then refusing when staff attempt to provide. The care plan always directed two staff in R1's room and indicated R1 was either elated or upset, would yell with cares, make false accusations of abuse by staff, and wanted instant gratification. The care plan directed staff to discuss behavior if reasonable, leave her alone to calm down when yelling at staff and validate feelings. A Grievance Report dated 12/21/24, written by R1 indicated she had been verbally abused by a staff member two or more times. During interview on 1/23/25 at 12:44 p.m., the social services designee (SSD) stated when R1 filed the grievance she had reached out to R1's family member (FM). The SSD stated the grievance was never filed because the FM told her not to even though R1 was her own decision maker and had filed the grievance. The SSD stated typically if a resident had a concern, they would ask them if they wanted to file a formal grievance and would then give the report to the DON and the administrator. The SSD stated the grievance was never turned into the administrator but said the concerns were reported to the DON. During interview on 1/23/25 at 2:16 p.m. the administrator stated if a grievance was filed in writing he expected the grievance to be responded to in writing. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Reporting a Grievance dated 1/9/17, indicated if a grievance is voiced by an individual or an individual's responsible party, the care center will make prompt efforts to investigate and resolve the grievance. The policy indicated the grievance officer was responsible for issuing grievance decisions to the resident. The policy indicated grievances would be investigated within 72 hours. Documentation should include the steps taken to investigate the grievance, a summary of pertinent conclusions, a statement as to whether the grievance was substantiated or not and the date the written conclusion was issued.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on interview and document review the facility failed to immediately report an allegation of abuse to the state agency, but no later than two hours, for 1 of 3 residents (R1) reviewed who alleged abuse from staff in the facility. Findings include: R1's Admission Record indicated she admitted to the facility on [DATE]. R1's diagnosis included cerebral palsy, post-traumatic stress disorder, bipolar disorder, and anxiety. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicted she displayed verbal behaviors during the assessment period. The MDS indicated R1 was dependent on staff for toileting and transfers. R1's care plan dated 12/11/24, identified a behavior problem; requesting task from staff, then refusing when staff attempt to provide. The care plan always directed two staff in R1's room and indicated R1 was either elated or upset, would yell with cares, make false accusations of abuse by staff, and wanted instant gratification. The care plan directed staff to discuss behavior if reasonable, leave her alone to calm down when yelling at staff and validate feelings. R1's Progress Notes identified the following: 12/27/24, R1 asked staff to make copies of a 6-7 page letter she had written to the administrator. Staff member made copies and gave the administrators copy to the registered nurse on duty. 12/31/24, The director of nursing (DON) was given a note from staff, written by this resident. In the note it stated multiple complaints about staff neglecting, abusing, and ignoring her. R1 had a history of accusing staff of those things. R1's family member was made aware of behaviors and stated R1 tended to get like that around the holidays. R1 had made statements to staff on multiple occasions it's all about me. Staff were interviewed and on this specific occasion stated R1 was upset because a staff member did not return to help her with cares when she said she would. 1/8/25. R1 had multiple complaints and stated she had hoped to discuss her concerns with the social services designee (SSD) and the administrator. R1 state she had written a letter to the administrator, hoping he would come and talk to her, but it had not happened. A letter dated 12/26/25, written by R1 to the administrator indicated she had been emotionally abused by almost all the staff on the p.m. shift. R1 also wrote, she did not feel she should have to put up with staff members intentional neglect and wrote she felt forgotten and felt the staff was purposely neglecting her. R1 further wrote in the letter, Who can I talk to about this p.m. shift abuse? A Grievance Report dated 12/21/24, written by R1, indicated a nursing assistant (NA) verbally abused me twice or more. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/23/25 at 12:06 a.m., R1 stated one of the staff members (NA-A) verbally abused her so she did not allow NA-A into her room because she did not want to be triggered. R1 stated she felt helpless and said, what do you do when someone treats you that way? R1 further stated she had written a letter to the DON and the administrator and said they never responded. During interview on 1/23/25 at 1:01 p.m. the DON stated the allegations were not reported to the SA because her care plan indicated a history of false accusations, so she did not feel there was really any neglect. The DON stated the administrator was made aware of the allegations and did not feel it was reportable. During interview on 1/23/25 at 2:16 p.m., the administrator stated when resident reports abuse the facility did an internal review to determine if the allegations were reportable to the SA. The administrator said if a resident had a history of making similar complaints the allegations would not be reportable. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, indicated care center must report to the SA any suspected maltreatment (all alleged violations involving abuse, neglect, financial exploitation or maltreatment, including injuries of unknown source and misappropriation of resident property) immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on interview and document review the facility failed to investigate an allegation of abuse for 1 of 3 residents (R1) reviewed when R1 reported an allegation of abuse. Findings include: R1's Admission Record indicated she admitted to the facility on [DATE]. R1's diagnosis included cerebral palsy, post-traumatic stress disorder, bipolar disorder, and anxiety. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and indicted she displayed verbal behaviors during the assessment period. The MDS indicated R1 was dependent on staff for toileting and transfers. R1's care plan dated 12/11/24, identified a behavior problem; requesting task from staff, then refusing when staff attempted to provide. The care plan directed two staff at all times in R1's room and indicated R1 was either elated or upset, would yell with cares, make false accusations of abuse by staff, and wanted instant gratification. The care plan directed staff to discuss behavior if reasonable, leave her alone to calm down when yelling at staff and validate feelings. R1's Progress Notes identified the following: 12/27/24, R1 asked staff to make copies of a 6-7 page letter she had written to the administrator. Staff member made copies and gave the administrators copy to the registered nurse on duty. 12/31/24, The director of nursing (DON) was given a note from staff, written by this resident. In the note it stated multiple complaints about staff neglecting, abusing, and ignoring her. R1 had a history of accusing staff of those things. R1's family member was made aware of behaviors and stated R1 tended to get like that around the holidays. R1 had made statements to staff on multiple occasions it's all about me. Staff were interviewed and on this specific occasion stated R1 was upset because a staff member did not return to help her with cares when she said she would. 1/8/25. R1 had multiple complaints and stated she had hoped to discuss her concerns with the social services designee (SSD) and the administrator. R1 state she had written a letter to the administrator, hoping he would come and talk to her, but it had not happened. A letter dated 12/26/25, written by R1 to the administrator indicated she had been emotionally abused by almost all the staff on the p.m. shift. R1 also wrote, she did not feel she should have to put up with staff members intentional neglect and wrote she felt forgotten and felt the staff was purposely neglecting her. R1 further wrote in the letter, Who can I talk to about this p.m. shift abuse? A Grievance Report dated 12/21/24, completed by R1 indicated a nursing assistant (NA) verbally abused me twice or more. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/23/25 at 12:06 a.m., R1 stated one of the staff members (NA-A) verbally abused her so she did not allow NA-A into her room because she did not want to be triggered. R1 stated NA-A came into her room after a 45-minute wait and said she asked NA-A, what if I was having a heart attack. R1 stated NA-A replied and said, I know you; you wouldn't be having a heart attack. R1 stated she felt helpless and said, what do you do when someone treats you that way? R1 further stated she had written a letter to the DON and the administrator and said they never responded. During interview on 1/23/25 at 1:01 p.m. the DON stated, regarding R1's allegations of abuse, she had multiple conversation with staff and with R1 but was unable to provide evidence of an investigation. During interview on 1/23/25 at 2:16 p.m., the administrator stated he would expect a thorough investigation including interviews with other residents. Facility policy Maltreatment Reporting Guidelines dated 11/26/24, indicated within five working days of submitting the initial report to the MDH/OHFC the reporter must submit a completed copy of the investigation to the SA.