

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 02/20/2025
NAME OF PROVIDER OR SUPPLIER Littlefork Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569</p> <p>Based on observation, interview and document review the facility failed to perform a comprehensive assessment of falls to include root cause and failed to implement appropriate interventions to reduce the risk for falls from bed for 1 of 3 residents (R2) reviewed who had multiple falls from bed.</p> <p>Findings include:</p> <p>R2's Admission Record indicated he admitted to the facility 5/6/24. R2's diagnosis included Alzheimer's disease, hemiplegia (severe or complete loss of movement function) and hemiparesis (mild to moderate weakness), dementia and insomnia.</p> <p>R2's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and indicated no hallucinations, delusions or behaviors were displayed. The MDS indicated R2 had upper and lower extremity impairments to one side and indicated he was independent with transfers and ambulation. R2's MDS indicated frequent bladder incontinence and occasional bowel incontinence and indicated he had two or more falls since the previous assessment.</p> <p>R2's care plan dated 1/9/25, identified a risk for falls related to confusion, incontinence, and a lack of awareness of safety needs. Interventions initiated 11/20/24, included staff to assist as needed with mobility and transfers, ensure call light in reach, provide a call, do not fall sign, non-skid strips on the floor and ensure appropriate footwear. The care plan further indicated R2 was close to the nurse's station for monitoring, added 1/9/25 and tape on the wall to determine appropriate bed height on 1/7/25. An untitled document indicated IDT reviewed falls on 11/26/24, R2 had already been moved closer to the nurse's station and indicated tape on the wall for bed height. The care plan further identified bowel incontinence and directed staff to check every two hours and assist with toileting as needed, added 11/19/24 and bladder incontinence, change every 2-3 hours, added 11/19/24.</p> <p>A review of R2's Fall reports, Progress Notes and correlating interdisciplinary team (IDT) reviews indicated the following:</p> <p>11/6/24 at 11:20 p.m., Staff heard R2 yelling and found him on the floor on the right side of the bed. R2 denied feeling short of breath or feeling dizzy or lightheaded. IDT action indicated, educate R2 on call light use and to sit for five minutes before standing.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>11/10/24 at 11:25 p.m., R2 was found lying on his left side on the floor next to his bed. R2 had gripper sock on and had one shoe on. R2 sustained skin tears to his right hand. IDT action indicated to make sure his shoes were on properly.</p> <p>11/17/24 at 4:45 a.m., staff found R2 on the floor next to his bed. Potential root cause indicated foam mattress pad. IDT action included moving R2 closer to the nursing station.</p> <p>11/30/24 at 11:30 p.m., staff found R2 sitting on the floor next to his bed. It appeared he had slid out of bed. IDT action indicated room check by staff walking by and started on Trazadone (an antidepressant that is sometimes prescribed as a sleep aid) to promote sleep.</p> <p>12/14/24 at 4:04 a.m., staff found R2 laying on the floor next to his bed.</p> <p>1/3/25 at 9:47 p.m., staff found R2 sliding off the edge of his bed. Progress Note dated 1/4/25, indicated R2 was trying to get up and slid off the bed. The note indicated it was a common occurrence as R2 often sat too close to the edge of the bed.</p> <p>1/29/25 at 5:44 p.m., R2 fell ambulating in the hallway.</p> <p>1/30/25 at 9:33 p.m., R2 was found on the floor next to his bed. R2 stated he fell out of bed.</p> <p>2/11/25 at 3:45 p.m. staff found R2 kneeling in front of his bed. R2 stated he slid out of bed. An untitled document indicated IDT. The document indicated reviewed the falls that occurred 1/29/25, 1/30/25 and 2/11/25, on 2/11/25. Care plan was reviewed and follow up in one week with physical therapy evaluation.</p> <p>2/11/25- IDT reviewed falls on 1/29, 1/30 and 2/11- Has been more unsteady, weaker with a significant change to be conducted. Has dementia and does not realize he needs assistance with transfers and toileting.</p> <p>R2's Bowel and Bladder Comprehensive assessment dated [DATE], indicated he was able to call for assistance to use the toilet. The assessment indicated R2 was always incontinent of bladder and bowel and required extensive assist to total dependence for all transfers and had impaired mobility. The assessment indicated a recent decline in mobility and with this there had been a noted increase in incontinence.</p> <p>R2's Fall Comprehensive assessment dated [DATE], indicated he sustained three or more falls since the previous assessment, had difficulty maintaining balance and identified gait problems. The assessment identified a high risk for falls and indicated he ambulated with assistance and at times transferred with assistance of a mechanical stand device.</p> <p>During observation on 2/19/25 at 12:15 p.m. R2 was seated at a table in the dining room wearing white socks that appeared to have nonslip circles on the bottom. During observation of R2's room at 1:54 p.m. grip strips were observed on the floor in front of the bed and the toilet. Signs that read, call do not fall were observed across from the bed on the wall by the entrance to the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 2/19/25 at 2:09 p.m. nursing assistant (NA)-A stated R2 basically slides out of bed. NA-A said R2 slept perpendicular on his bed and used to walk independently but did not anymore.</p> <p>During interview on 2/19/25 at 2:21 p.m., registered nurse (RN)-A stated R2 had a diagnosis of Alzheimer's and was very impulsive and wants to do what he wants to do. RN-A said R2 had impairments to his right side and when he tried to get up too fast, he tripped on the bed. RN-A said R2 laid on the bed with is bottom half hanging off and said that was the reason for many of his falls.</p> <p>During interview on 2/19/25 at 3:35 p.m., the director of nursing (DON) stated after a fall the IDT members reviewed the falls and completed an analysis of the fall to determine root cause and put interventions in place based on the cause. The DON stated they had identified most of R2's falls occurred late at night and early morning and said they had implemented interventions that included closer supervision, room near the nurse's station and said recently R2 had been ill and had started to fall again.</p> <p>During interview on 2/20/25 at 11:00 a.m. The DON, assistant director of nursing (ADON) and RN-B were interviewed. The ADON said at one time they had physical therapy adjust the height of the bed and place tape on the wall and applied grip strips to the floor. The ADON said R2 had mobility issues and had some increased weakness and would slide off the bed. The ADON also said R2 laid sideways on the bed. The ADON said a physical therapy evaluation had been done last week but she had not seen it yet. ADON stated the fall interventions should still be appropriate and said it was hard to find new interventions.</p> <p>Facility Policy Fall Prevention and Management dated 6/5/23, indicated a falls analysis will be completed when a resident has two or more falls, to review fall trends, identify individual and systemic causes of falls, evaluate current interventions for effectiveness and if needed to determine additional interventions. The IDT will systematically review the fall and interventions put into place to determine their effectiveness. If an intervention is not effective or appropriate to the root cause, new interventions will be developed and implemented.</p>		