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	08/06/2025

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 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. (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure timely reporting of an allegation of resident to resident abuse to the state agency (SA) for 2 of 2 residents (R1, R2) reviewed for abuse.Findings include:R1's admission Record indicated he admitted to the facility 1/10/25, with diagnosis that included neurocognitive disorder with [NAME] bodies, dementia with mood disturbance, agitation and psychotic disturbance.R1's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated he displayed physical, verbal and other behaviors 1-3 days during the assessment period. The MDS indicated R1 ambulated independently.R1's care plan dated 5/22/25, identified a risk for harm to self or others. The care plan directed staff to approach R1 from the side when upset, hold hands gently when attempting to re-direct, and if he posed a potential threat to self or others, approach calmly and speak directly to him. The care plan further directed nursing to contact law enforcement to send to the emergency department (ED) when aggressive and not directable.R1's Progress Notes indicated the following:7/22/25, At approximately 2:30 p.m., R1 was standing at the nurses station and had a friendly conversation with R2. R1 walked away, then turned back around and Grabbed onto R2's walker. R2 asked him to let go and R1 yelled at her and pushed R2 backwards. Before staff could interfere, R1 struck R2 in the chest. Staff assisted R2 to keep from falling and R1 continued to reach around and grabbed and punched at R2. R1 connected with R2's chest and shoulder at least three times. R2's admission Record indicated she admitted to the facility 3/14/24. Diagnosis included cerebral infarction (stroke), hyperlipidemia and hypertension.R2's quarterly MDS dated [DATE] indicated her short term memory was okay. The MDS indicated R2 displayed verbal and physical behaviors 1-3 days during the assessment period and indicated she ambulated independently.R2's Care Plan dated 4/9/25, identified a potential to be verbally aggressive related to poor impulse control and directed staff to guide away from source of distress. A facility incident report dated 7/22/25, indicated At approximately 2:30 p.m., R2 was standing at the nurses station. R1 was also standing there having a snack. R1 walked away, then turned back around and grabbed R2's walker. R2 very kindly asked him to let go and his behavior changed instantly. R1 yelled at R2 and pushed her back. Before staff could intervene, R1 struck R2 in the chest. Staff stepped between the two residents but R1 continued reaching around the staff and grabbed and punched at R2. The report indicated R2 sustained injury to her right shoulder and reported pain rated 7/10 to her right shoulder and neck. R2 also had a lump on the front of her right bicep.During interview on 8/8/25 at 12:45 p.m., the social service designee (SD) stated she had completed a report right away after the incident occurred but said she had not reported to the correct agency.During interview on 8/6/25 at 10:10 a.m., the administrator stated the incident had not been reported to the SA timely and said after the corporate consultant identified it had not been reported, she reported the incident to the SA.Facility policy Maltreatment Reporting Guidelines dated undated indicated if suspected maltreatment occurred, report to the SA immediately, but not later than 2 hours after the allegation is made if the incident involves abuse, neglect, or financial exploitation that results in serious bodily injury, including injuries of unknown source and misappropriation of VA property.

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to provide notice of intent to discharge for 1 of 1 residents (R1) who was sent to the hospital and discharged from the facility.Findings include:R1's admission Record indicated he admitted to the facility 1/10/25, with diagnosis that included neurocognitive disorder with [NAME] bodies, dementia with mood disturbance, agitation and psychotic disturbance.R1's quarterly Minimum Data Set, dated [DATE], identified severe cognitive impairment and indicated he displayed physical, verbal and other behaviors 1-3 days during the assessment period. R1's care plan dated 5/22/25, identified a risk for harm to self or others. The care plan directed staff to approach R1 from the side when upset, hold hands gently when attempting to re-direct, and if he posed a potential threat to self or others, approach calmly and speak directly to him. The care plan further directed nursing to contact law enforcement to send to the emergency department (ED) when aggressive and not directable.R1's Progress Notes indicated the following:7/22/25, At approximately 2:30 p.m., R1 was standing at the nurse's station and had a friendly conversation with R2. R1 walked away, then turned back around and Grabbed onto R2's walker. R2 asked him to let go and R1 yelled at her and pushed R2 backwards. Before staff could interfere, R1 struck R2 in the chest. Staff assisted R2 to keep from falling and R1 continued to reach around, grabbing and punching at R2. R1 connected with R2's chest and shoulder at least three times. R1 was taken to the emergency department.7/24/25, Facility staff received a phone call that R1 would be returning to the facility. Direction from facility administrator was to notify hospital not to accept R1 for re-admission.7/25/25, R1 had been officially discharged from the facility and is being placed in a behavioral health unit.A facility incident report dated 7/22/25, indicated At approximately 2:30 p.m., R2 was standing at the nurses station. R1 was also standing there having a snack. R1 walked away, then turned back around and grabbed R2's walker. R2 very kindly asked him to let go and his behavior changed instantly. R1 yelled at R2 and pushed her back. Before staff could intervene, R1 struck R2 in the chest. Staff stepped between the two residents but R1 continued reaching around the staff and grabbed and punched at R2. The incident report indicated R1 was sent to the emergency department for placement elsewhere.During interview on 8/6/25 at 10:10 a.m., the administrator stated R1 was in a behavioral health unit and said the facility had discharged him due to his aggression. The administrator said when the hospital called and wanted to send him back to the hospital the facility did not take him back and said they did not have the resources to give him what he needed. The administrator stated they had discussed a memory care unit with R1's family but said she did not know what the families plan for R1 was. A facility discharge policy was requested but not received.