Printed: 04/30/2025
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 02/27/2025

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on observation, interview and document review, the facility failed to ensure the state agency (SA) survey results were available for residents voiced by 2 of 3 residents (R4, R25) who attended resident council meetings. In addition, the facility failed to ensure the most recent SA survey results were readily accessible at all times. This had the potential to affect all 38 residents and families that may wish to review the results. Findings include: R4's quarterly Minumum Data Set (MDS) dated [DATE], indentified R4 was cognitively intact. R25's annual MDS dated [DATE], indentified R25 was cognitively intact. During the resdient council meeting on 2/25/25 at 2:27 p.m., R4 and R25 were in attendance. Both residents stated they regularily attended resident council meetings. R4 and R25 were aware the SA survey results were to be available, although did not know where the results were located. During observation on 2/25/25 at 2:04 p.m., there was a binder hanging on the wall across from the nurses station near the main entrance to the facility. The binder was labeled Minnesota Department of Health Survey Results on the front and MDH Survey Results on the spine of the binder. Review of the survey binder identified the most recent posted survey result was dated 12/5/22. There was no notice identfiying the last three years survey results were available upon request and who to request them from. The binder lacked the following surveys: - 2/6/23, stand-alone abbreviated survey - 7/25/24, stand-alone abbreviated survey - 9/5/24, stand-alone abbreviated survey - 9/26/24, stand-alone abbreviated survey - 1/23/25, stand-alone abbreviated survey (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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	- 2/19/25, stand-alone abbreviated survey - 2/26/25, recertification survey On 2/27/25 at 4:14 p.m., the director of nursing (DON) stated the survey binder should have the past three years of survey results available for residents, family and visitors to review. The DON stated the last posted survey in the binder was dated 12/5/22. A policy for survey binder posting was requested but not received.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review the facility failed to timely notify the physician when a hematoma (localized collection of blood outside of blood vessels) was identified and subsequently opened requiring a new intervention for 1 of 2 (R18) residents reviewed for wound care. Findings include: R18's significant change Minimum Data Set (MDS) dated [DATE], identified R18 had severe cognitive impairment and did not exhibit behaviors during the assessment period. Diagnoses included Alzheimer's disease and a methicillin-resistant staphylococcus aureus (MRSA) infection. R18 had an open lesion other than ulcers, rashes or cuts. No pressure, venous or arterial ulcers. R18's undated care plan, identified R18 had impaired skin integrity due to a tissue injury. Staff were directed to encourage R18 to elevate legs, R18 had an air mattress on my bed, measure ulcer on at regular intervals, monitor ulcer for signs of infection, monitor ulcer for signs of progression or declination, notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. R18's nursing progress note dated 11/22/24 at 1:15 a.m., identified a loud scream was heard and then a crash. R18 was found almost up against the door. Staff had to push the door open until staff could fit through. Stepped over R18 walker R18 was sitting up against her closet. R18 was confused. R18 said she was just getting up. R18 did say she hurt everywhere A quick exam was done. R18 asked to be put back to bed. When R18 was put in bed, nursing assistant noted a big black bruised lump on her right inner shin. R18 continues to say she hurt everywhere. Vitals were obtained while phones calls were made to R18's son. At 1:30 am., R18's son said to send her to the emergency room . On-call RN was notified. R18's medical record failed to identify R18's hematoma until 12/12/24. R18's Skin/Wound note dated 12/12/24 at 2:19 p.m., identified the medical director (MD) was in the facility doing monthly wound rounds. R18 was sitting in the hallway in her wheelchair and nursing asked MD to take a look at R18's leg and assess. The MD examined the right calf and stated that area appeared to be a hematoma in which the skin was fully intact. R18 asked the provider if there was anything MD could give R18 to take care of it and MD told R18 that it just takes time to heal. MD stated to the current plan of care was adequate and that no further treatment was needed at this time. R18's N Adv - Skin Check dated 12/12/24 at 2:43 p.m., identified bruising purple and red inner lower right leg approximately 18 centimeter (cm) x 10cm, warm with dark purple raised area in middle of 2 cm x 2 cm, skin intact. R18's Skin/Wound note dated 12/19/24 at 7:30 a.m., identified the hematoma on R18's right leg broke open during the night and bled all over her bed. Old dressing was taken off and the swelling had gone down, and copious amounts old blood was draining from the wound. The note failed to identify if R18's physician was notified of R18's change in condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Skin/Wound note dated 12/19/24 at 5:03 p.m., identified wound dressing to R18's lower right extremity was changed again this afternoon due to bleeding through the dressing. Copious amounts of old blood were coming out of the hematoma wound itself. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/21/24 at 1:02 a.m., identified changed wound dressing to R18's right lower extremity due to bleeding through the dressing. The wound to mid-calf had copious amounts of serosanguineous drainage saturating the dressing. R18 tolerated dressing change without concern or complaint. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/21/24 at 10:27 a.m., identified R18 got a shower that morning. Dressing to R18's wounds on her right leg were changed and redressed. Hematoma did not have any drainage on old dressing but skin tear near the ankle had a small amount of greenish drainage noted on old dressing. The note failed to identify if R18's physician was notified of R18's change in condition. R18's nursing progress note dated 12/26/24 at 12:18 p.m., identified R18 had been out for both meals that morning. R18 denied any pain, unless she bumped her right leg on something. No new injuries or new bruises have been noted. Dressing to her right lower extremity continued to drain and did have an odor to it. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Transfer Out of Building note dated 12/23/24 at 2:52 p.m., identified dressing change was being done on right skin, wound appears to be worsening, a photo was sent to the medical director (MD) and per MD, R18 sent to the ER. During an interview on 2/27/25 at 1:40 p.m., RN-A stated she responsible for the facility's wound care. RN-A was not aware of R18's tissue injury until 12/12/24. The MD was in the building and RN-A asked for the MD to evaluated R18. Point of care (POC) treatment (measuring and monitoring) was ordered. Then, on 12/19/24, the deep tissue injury opened. RN-A was not working that day and RN-A was not informed until 12/23/24. RN-A contacted the MD and received an order to send R18 to the emergency room for evaluation. RN-A stated the on-call RN should have contacted the physician on 12/19/24 to update on R18's condition and request dressing orders. During a phone interview on 2/27/25 at 2:43 p.m., the MD stated he was not R18's primary physician but was the medical director for the facility. The MD did evaluate R18 on 12/12/24 and R18 had a large hematoma to the upper right shin. The area was not warm to the touch or open. The MD recommended monitoring the area for changes. MD was notified on 12/19/24, R18's hematoma had opened and the MD recommended transfer to the emergency room for evaluation. Normally, the MD would expect staff to contact the primary physician unless the physician was unavailable and to do so on 12/19/24 when R18's condition had changed. During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated any bruise/deep tissue injury should be followed and documented daily and/or when there were changes. The physician should have been notified on 12/19/24 when R18's condition had changed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Notification of Significant Changes revised 5/22/22, identified the facility would immediately inform the resident, consult with the physician, and notify the resident representative (consistent with his or her authority), when the resident had a significant change. The primary physician will be updated during regular business hours. If the primary physician is not available, the on-call physician will be updated, and the primary provider will be sent notification.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview, and document review, the facility failed to ensure the care plan was updated timely to to prevent falls for 1 of 1 residents (R19) reviewed for falls. Findings include: R18's significant change Minimum Data Set (MDS) dated [DATE], identified R18 had a severe cognitive impairment and diagnoses that included Alzheimer's disease, dementia and osteoporosis. R18 had a fall without injury and a fall with injury. R18 did not use an alarm or any physical or electronic device that monitored R18's movement and alerted staff when movement was detected. R18's care plan revised 2/6/25, identified R18 was at risk for all related to confusion. Interventions included: - Assist R18 as needed with mobility and transfers - Be sure R18's call light was within reach and encourage R18 to use it for assistance as needed. - Bed in lowest position - Ensure that R18 was wearing appropriate footwear shoes when up ambulating or mobilizing in wheelchair and gripper socks when in bed. - R18 did not remember that R18 needed assistance with transfer or ambulation, anticipate needs. - R18 had a Bed sensor on R18's wall. - R18 had an easy touch call light under sheet, under R18's hip on R18's bed. - R18 needed a safe environment with floors free from spills and/or clutter; personal items within reach, gripper strips on floor in front of bed, recliner, and toilet - Keep R18 wheelchair next to R18 during meals and activities - R18 fall risk would be assessed every quarter and with change in condition R18's Incident Forms identified the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11/7/24 at 8:45 a.m., identified R18 was heard yelling out for help, she was found lying on the floor in the hallway off the dining room. R18 was laying on the floor, laying on her right side. R18 stated she was walking to eat, and her knees just gave out and she fell to her knees and then fell to her right side. R18 would have been in bed three hours prior to fall. At 7:30 a.m., staff walked resident out to the dining room for breakfast. R18 was evaluated in the emergency room . Fall interventions included: physician reviewed medications, continue with present care plan, staff to offer to assist back to room when done with meals. However, the care plan was not revised to reflect this updated intervention. - 11/15/24 at 3:00 p.m., R18 was found lying on the floor. Fall interventions included toilet every two hours and follow care plan. However, the care plan was not revised to reflect this. - 11/22/24 at 1:15 a.m., identified R18 was found lying on the floor. Fall intervention included a flat sensor placed under sheet under hip. However, the care plan was not revised to reflect this until 12/3/24. - 11/22/24 at 11:40 p.m., identified R18 was found lying on her left side next to her bed. Fall interventions included to place flat sensor under sheet under hip on bed. Referred to maintenance t to order. However, the care plan was not revised to reflect this until 12/3/24. During an interivew on 2/27/25 at 1:09 p.m., RN-E stated R18 was at risk for falls and R18's care plan was not revised to reflect toileting every two hours and/or for staff to assist R18 back to her room after meals. During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated staff were expected to revise resident care plans with identified fall interventions and were expected to follow the care plans to attempt to prevent further falls. The facility policy Person Centered Care Planning revised 12/18/23, identified the facility would will develop a comprehensive person-centered care plan with the resident and/or family representative for each resident in the facility, consistent with the resident's rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the resident's comprehensive assessment. The resident's care plan was reviewed every 90 days or more frequently if necessary with a significant change. Care plans were updated on an ongoing basis as needed based on changes that occur between care conferences.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and record review, the facility failed to ensure assistance was offered with meal setup to promote safety and independence with eating for 1 of 1 resident (R38) reviewed for activities of daily living (ADL) and needed set up and supervision to eat. Findings include: R38's admission Minimum Data Set (MDS) dated [DATE], identified R38 had intact cognition and required supervision or touching assistance with eating, maximum assistance with dressing and grooming and was dependent on staff for toileting, and transfers. Diagnoses included hemiplegia following cardiovascular disease and venous insufficiency. R38's Occupational Therapy (OT) Evaluation dated 2/7/25, identified R38 required supervision with eating and assistance to cut up his food. R38's Speech-Language Pathology Evaluation dated 2/11/25 identified R38 was edentulous (without teeth) and had top and bottom dentures but chose not to wear them. R38 was admitted on a soft and bite sized diet. R38 reported he was not having difficulty with regular textured food and would like to be upgraded. R38's progress note(s) identified the following: - 2/6/25, identified R38 was eating lunch in his room when his friend came to visit. The friend was upset that the lunch tray had been left for R38 in his room but had not been prepared so he could eat it. It was determined R38 should eat in dining area for his meals to ensure he received the assistance when needed. - 2/12/25, R38 required supervision with eating and setup of his meal trays. R38 was a choking risk and was required to be in the dining room for meals to be observed. R38 was unable to cut up his foods and required food to be cut up small to prevent choking. R38's care plan dated 2/12/25, identified R38 had a swallowing problem related to coughing or choking during meals or swallowing medications. Interventions included for all staff to be informed of resident's special dietary and safety needs, eat only with supervision and to instruct R38 to eat in upright position, eat slowly and chew each bite thoroughly. R38 had hemiparesis on his left side and staff were to discuss concerns or issues regarding diagnosis. R38's care plan failed to identify R38's preference to have his food cut into small bites and/or his inability to cut up the food into small bites himself due to limited range of motion as assessed by OT. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25, at 12:05 p.m. R38 was observed sitting at the dining room at a table in the back, away from most of the other residents and staff. R38 was served a sloppy joe bun cut into quarters, whole french fries, a lettuce salad and two cups of liquid in covered cups with straws. R38 made no attempt to eat and remained seated in his wheelchair with his hands in his lap. At 12:25 p.m. R38 stated he was hungry but he did not think he could eat the food in front of him. He needed it cut up or something different. Three staff members were in the dining room assisting other residents, however, no one approached R38 to offer assistance. At 12:44 p.m. R38 remained seated in his wheelchair with his hands in his lap and food untouched. No staff approached him to offer assistance. At 4:47 p.m. the director of nursing (DON) approached R38 and asked if she could assist him. R38 stated he was hungry but could not eat the meal and needed to have help to cut it up. The DON noticed R38 was overly warm and obtained another staff member to assist him to his room, bringing his lunch tray with him. During joint interview on 2/27/25, at 9:10 a.m. with nursing assistant (NA)-A and NA-H, NA-A stated R38 did not need help to eat but needed to eat in the dining room for supervision. NA-H stated R38 needed to have his food cut up in very small bites in order for him to eat. When interviewed on 2/27/25, at 9:44 a.m. registered nurse (RN)-B stated it was an issue if R38 had not gotten assistance to cut his food in small pieces. Cutting his sloppy joe bun into quarters and serving whole baked french fries was not small bite size pieces and she was not sure if he should have even been served french fries as they would be difficult for him to eat. When staff put the plate of food in front of him they should immediately cut up the food into small bite size pieces. RN-B always asked R38 what she could do for him when she delivered his food. RN-B stated residents should be checked on in the dining room and 45 minutes was to long not to have someone to have had checked with him and offer assistance. During interview on 2/27/25, at 1:45 p.m. dietary aide (DA)-A stated if a resident had an order to have food cut up small and bite sized, the dietary staff would do that before serving the resident the meal. A sandwich cut into quarters and whole crispy french fries would not be considered small and bite sized. DA-A did not think R38 had an order for small bite sized food anymore. R38 had graduated to a regular diet level and just could not have any food on the bone and his bacon needed to be soft. The dietary order indicated he was to take small bites and sips and alternate between bites and sips but not for dietary to cut up the food in small bites. R38's medical record lacked documentation R38's dietary needs, assistance with eating and food preferences had been reassessed, after being upgraded to a regular diet. During interview on 2/27/25, at 2:12 p.m. the director of nursing (DON) stated staff should have checked with R38 in the dining room when he had not attempted to eat. There wasn't a physician order to cut up R38's food in small bite size pieces but she would have expected the intervention to be on his care plan or at least to offer assistance with every meal. The facility's undated policy Activities of Daily Living, identified the purpose was to provide assistance to residents as necessary, to supervise and assess resident function in order to plan care to maintain optimum ADL function and to improve quality of life.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to perform ongoing monitoring and wound care for an injury for 1 of 2 residents (R18) reviewed for wound care; and the facility failed to implement interventions for edema for 1 of 1 resident (R38) reviewed for edema. Findings include: R18: R18's significant change Minimum Data Set (MDS) dated [DATE], identified R18 had severe cognitive impairment and did not exhibit behaviors during the assessment period. Diagnoses included Alzheimer's disease and a methicillin-resistant staphylococcus aureus (MRSA) infection. R18 had an open lesion other than ulcers, rashes or cuts. No pressure, venous or arterial ulcers. R18's undated care plan, identified R18 had impaired skin integrity due to a tissue injury. Staff were directed to encourage R18 to elevate legs, R18 had an air mattress on my bed, measure ulcer on at regular intervals, monitor ulcer for signs of infection, monitor ulcer for signs of progression or declination, notify provider if no signs of improvement on current wound regimen and provide wound care per treatment order. R18's nursing progress note dated 11/22/24 at 1:15 a.m., identified a loud scream was heard and then a crash. R18 was found almost up against the door. Staff had to push the door open until staff could fit through. Stepped over R18 walker. R18 was sitting up against her closet. R18 was confused. R18 said she was just getting up. R18 did say she hurt everywhere A quick exam was done. R18 asked to be put back to bed. When R18 was put in bed, nursing assistant noted a big black bruised lump on her right inner shin. R18 continues to say she hurt everywhere. Vitals were obtained while phones calls were made to R18's son. At 1:30 am., R18's son said to send her to the emergency room . On-call RN was notified. R18's N Adv - Skin Check dated 12/2/24 at 10:13 a.m., identified a skin tear on R18's right lower leg. However, the note failed to identify R18's hematoma (an abnormal pooling of blood in the body under the skin that results from a broken or ruptured blood vessel) on the upper right shin. R18's medical record failed to identify R18's hematoma until 12/12/24. R18's Skin/Wound note dated 12/12/24 at 2:19 p.m., identified the medical director (MD) was in the facility doing monthly wound rounds. R18 was sitting in the hallway in her wheelchair and nursing asked MD to take a look at R18's leg and assess. The MD examined the right calf and stated that area appeared to be a hematoma in which the skin was fully intact. R18 asked the provider if there was anything MD could give R18 to take care of it and MD told R18 that it just takes time to heal. MD stated to the current plan of care was adequate and that no further treatment was needed at this time. R18's N Adv - Skin Check dated 12/12/24 at 2:43 p.m., identified bruising purple and red inner lower right leg approximately 18 centimeter (cm) x 10 cm, warm with dark purple raised area in middle of 2 cm x 2 cm, skin intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Order Summary Report dated 12/14/24, identified treatment for open wound on right upper calf shallow crater: With minimal drainage, apply generous layer of protective ointment/ Bacitracin Zinc (an antibiotic ointment). Cover with non-adherent foam dressing. Secure with rolled gauze. Change every other day. R18's Skin/Wound note dated 12/19/24 at 7:30 a.m., identified the hematoma on R18's right leg broke open during the night and bled all over her bed. Old dressing was taken off and the swelling had gone down, and copious amounts old blood was draining from the wound. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/19/24 at 5:03 p.m., identified wound dressing to R18's lower right extremity was changed again this afternoon due to bleeding through the dressing. Copious amounts of old blood were coming out of the hematoma wound itself. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/21/24 at 1:02 a.m., identified changed wound dressing to R18's right lower extremity due to bleeding through the dressing. The wound to mid-calf had copious amounts of serosanguineous drainage saturating the dressing. R18 tolerated dressing change without concern or complaint. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Skin/Wound note dated 12/21/24 at 10:27 a.m., identified R18 got a shower that morning. Dressing to R18's wounds on her right leg were changed and redressed. Hematoma did not have any drainage on old dressing but skin tear near the ankle had a small amount of greenish drainage noted on old dressing. The note failed to identify if R18's physician was notified of R18's change in condition. R18's nursing progress note dated 12/26/24 at 12:18 p.m., identified R18 had been out for both meals that morning. R18 denied any pain, unless she bumped her right leg on something. No new injuries or new bruises have been noted. Dressing to her right lower extremity continued to drain and did have an odor to it. The note failed to identify if R18's physician was notified of R18's change in condition. R18's Transfer Out of Building note dated 12/23/24 at 2:52 p.m., identified dressing change was being done on right skin, wound appears to be worsening, a photo was sent to the MD and per MD, R18 sent to the ER. (continued on next page)

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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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Hospital Discharge Summary dated 12/30/24, identified R18 presented from outside ER, for surgical management of her right lower extremity wound. R18 had a fall about a month ago and developed a hematoma. About two weeks ago, R18 started having drainage from that wound. R18 was transferred to the ER yesterday because of worsening wound and purulent discharge. R18 does not remember, she had underlying dementia and was not able to provide any history. Right lower extremity wound with purulent (consisting of, containing, or discharging pus) drainage. R18 underwent debridement (the surgical process of removing dead skin and foreign material from a wound. This can help to reduce the risk of infection and promote healing) on 12/25/24. R18's CT (a series of X-rays and a computer to create detailed images of your bones and soft tissues) shows soft tissue defect (refer to localized or multifocal pathologic syndromes involving the periarticular tissues, including muscle, tendon, ligament, fascia, aponeurosis, retinaculum, bursa, and subcutaneous tissue) involving medial mid lower leg 6 cm x 1.7 cm. Antibiotics were previously, vancomycin cefepime and Flagyl. Most recently on cephalexin. Wound culture over the weekend showed MRSA (Methicillin-resistant Staphylococcus aureus) (a type of bacteria that many antibiotics don ' t work on) and Morganella (a species of Gram-negative bacteria. It has a commensal relationship within the intestinal tracts of humans, mammals, and reptiles as normal flora. Although M. morganii has a wide distribution, it is considered an uncommon cause of community-acquired infection, and it is most often encountered in postoperative and other nosocomial (acquired while admitted to a health-care facility) infections), both sensitive to treatment. During a phone interview on 2/27/25 at 12:02 p.m., registered nurse (RN)-D stated R18 had a wound on her leg that R18 had gotten during a fall in her room. It began as a large hematoma. It was about the size of a golf ball, hard to touch, deep dark purple in color. Staff did look at it, but didn't do anything else. RN-D was unsure when but was told by another RN, the area had broken open. RN-D wasn't sure if R18 had bumped it or if it opened on its own, but it started to bleed out. The RN had said there was more underneath it. RN-D stated she couldn't remember the exact details but R18 had gone to the emergency room and was transferred to another hospital from there. When R18 returned from the hospital, R18 had a wound vac (vacuum-assisted closure) is a therapeutic technique used to promote healing in acute or chronic wounds and burns. It involves using a suction pump, tubing, and a dressing to remove excess exudate, reduce swelling, clean the wound, and remove bacteria.) and declined a lot from there. During an interview on 2/27/25 at 1:09 p.m., RN-E stated R18 was hospitalized due to an open wound and came back with a wound vac. However, RN-E stated she was aware of the where the original injury that caused the wound came from. During an interview on 2/27/25 at 1:40 p.m., RN-A stated she responsible for the facility's wound care. RN-A was not aware of R18's wound until 12/12/24. The MD was in the building and RN-A asked for the MD to evaluated R18. Point of care (POC) treatment (measuring and monitoring) was ordered. Then, on 12/19/24, the deep tissue injury opened. RN-A was not working that day and RN-A was not informed until 12/23/24. RN-A contacted the MD and received an order to send R18 to the emergency room for evaluation. RN-A stated the on-call RN should have contacted the physician on 12/19/24 to update on R18's condition and request dressing orders. Further, RN-A stated she should have been informed of R18's tissue injury on 11/22/24 so the area could be monitored and cared for appropriately. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 2/27/25 at 2:43 p.m., the MD stated he was not R18's primary physician but was the medical director for the facility. The MD did evaluate R18 on 12/12/24 and R18 had a large hematoma to the upper right shin. The area was not warm to the touch or open. The MD recommended monitoring the area for changes. The MD then was notified on 12/19/24, R18's hematoma had opened and the MD recommended transfer to the emergency room for evaluation. Normally, the MD would expect staff to contact the primary physician unless the physician was unavailable and to do so on 12/19/24 when R18's condition had changed. MD was not sure if the outcome would have been different for R18. During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated an injury should be followed and documented daily and/or when there were changes. The physician should have been notified on 12/19/24 when R18's condition had changed. The facility policy Skin Integrity dated 11/26/24, identified nursing staff will monitor resident's skin integrity and address issues promptly while providing care and services consistent with professional standards of practice. NEW SKIN INTEGRITY ISSUE A. Care center staff will notify the licensed nurse when a new skin integrity issue is observed. B. Licensed nurse will: a. Assess the area and identify the cause, if possible. b. Remove any source of pressure or trauma to the area. c. Clean the area and provide treatment per care center House Standing Orders. d. Determine if the skin integrity issue is reportable to the State Agency (SA). If yes, notify the Administrator and Director of Nursing and proceed with the SA reporting process. (CCEP.MP.005 Maltreatment Investigation & Reporting) e. Complete a Skin Incident report in the resident EHR. f. Notify resident and/or responsible party. g. Notify Provider and request treatment orders, if applicable. h. Notify the Nurse Manager, Wound Nurse, or designee. i. Initiate a new tissue tolerance for any newly opened area or redness. j. Initiate appropriate preventive measures based on the immediate root cause. C. Nurse Manager, Wound Nurse, or designee will assess and complete a root cause analysis. D. Interdisciplinary Team (IDT) will review the skin incident report and evaluation of root cause for further recommendations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. Provider will review, to diagnosis, if root cause was not related to an injury (i.e., skin tear, bruise), make recommendations, and/or initiate order(s). F. Nurse Manager, Wound Nurse, or designee will review/update the resident's current care plan. Intervention(s) will be initiated, as needed, based on resident/representative input, assessments, and Provider orders. MONITORING A. A licensed nurse will complete the skin check weekly and documented in the EHR. B. Nurse Manager, Wound Nurse, or designee will assess all applicable wounds weekly including pressure ulcers, venous ulcers, arterial ulcers, diabetic ulcers, MASD, other wounds of concern. a. Documentation will be completed in the resident electronic health record and will include describing the following characteristics: i. Location ii. Stage if pressure ulcer iii. Measurements, including any undermining or tunneling/sinus tract. iv. Exudate v. Pain vi. Wound bed vii. Wound edges and surrounding tissue viii. Signs and symptoms of infection ix. Progress towards healing x. Current interventions, including treatment, and any changes made to plan of care. b. Provider will be notified of any significant changes and/or a delay in healing. C. Licensed Nurse will observe and measure weekly all skin integrity issues that are not followed by the Nurse Manager, Wound Nurse, or designee. a. Documentation will be completed in the EHR and will include escribing the following characteristics: i. Location ii. Measurements (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iii. Exudate iv. Pain v. Signs and symptoms of infection vi. Progress toward healing b. If any significant changes are observed and/or delay in healing, notify the Nurse Manager, Wound Nurse, or designee and Provider. D. Licensed Nurse will observe changes in skin integrity and treatments. Will notify the Nurse Manager, Wound Nurse, or designee with any changes. E. Pressure ulcers will be observed daily by the licensed nurse. Documentation will include: a. Evaluation of pressure ulcer if no dressing present. b. Evaluation of the status of the dressing if present (intact, draining, and/or leaking). c. Status of area surrounding (observed without removing dressing). d. Presence of complications (i.e., increasing size, drainage, redness, swelling). e. Pain, if present, adequately controlled. F. Nurse Manager, Wound Nurse, or designee will update resident and/or representative with any significant change G. Provider to assess wound(s) during routine visits and will make any referrals, recommendations, or treatment changes based on assessment/evaluation. H. Care center may utilize wound care specialists. I. Nurse Manager, Wound Nurse, or designee will track and trend skin integrity issues. Tracking and trending reports will be included in QAPI meetings. If the QAPI committee identifies significant causative factors and/or specific trends and patterns, measures will be taken to correct the identified areas. 41575 R38: R38's admission MDS dated [DATE], identified R38 had intact cognition and required maximum assistance with dressing and grooming. R38 was dependent on staff for toileting, and transfers. Diagnoses included hemiplegia following cerebrovascular disease and venous insufficiency. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R38's care plan dated 2/11/25, identified R38 received diuretic therapy for edema (swelling) and hypertension. Interventions included to administer diuretic medications as ordered and monitor for effectiveness and side effects. The care plan also included a focus that R38 had a diagnosis of peripheral vascular disease. Interventions included to educate on importance of proper foot care, elevate legs when sitting or sleeping and to monitor for excessive edema. R38's Order Summary Report dated 2/26/25, identified an order to apply Ace Wraps to his legs each morning before getting out of bed and to remove the wraps at bedtime. The care plan did not idenitfy the Ace Wraps were ordered or who was respondible for applying them. On 2/24/25, at 1:05 p.m. R38 was observed sitting in his wheelchair in his room watching television. R38's legs and feet were in a dependent position with his feet resting on the wheelchair foot pedals and had visible edema present on both his legs, from his knees to his feet. R38 stated the swelling in his legs was not a new problem for him but the doctor had recently ordered wraps to his legs for the swelling. Two long Ace Wraps were resting on R38's bedside table in a pile. R38 stated the staff did not put them on that morning and he was not sure why they had not been applied. On 2/25/25, at 10:58 a.m. R38 was again seated in his wheelchair in his room watching television. R38 was fully dressed and his legs and feet were in a dependent position with his feet resting on the wheelchair foot pedals. Edema was visibly present on both legs and feet. Ace Wraps were observed on R38's bedside table. R38 stated he did not know why staff had not applied the wraps to his legs when assisting him that morning. When interviewed on 2/25/25, at 11:25 a.m. nursing assistant (NA)-E stated she had assisted R38 to get dressed that morning. She did not put R38's Ace Wraps on as that was the nurses duty to do them. NA-E had not even known R38 needed wraps to his legs but she had seen them in his room that morning. During interview on 2/25/25, at 11:26 a.m. licensed practical nurse (LPN)-A stated R38 was supposed to have Ace Wraps on his legs. LPN-A had not been able to get to R38 yet. LPN-A stated R38 really should have them on before he gets out of bed in the morning. Wrapping his legs should be scheduled for night shift to do in the morning, as R38 was usually up and dressed before the day shift got out of report and she planned to change the scheduled time so it would not get missed again. During interview on 2/27/25, at 9:44 a.m. registered nurse (RN)-B stated R38's Ace Wraps should be applied daily and done before he got out of bed in the mornings. RN-B stated the problem with not putting the wraps on before he got up was that his legs tended to swell up quickly and if you waited to long, the swelling would have already happened. During interview on 2/27/25, at 2:12 p.m. the director of nursing (DON) stated she would have expected staff to apply R38's wraps as ordered prior to getting up in the mornings. The wraps were ordered to decrease the inflammation and dependent edema in R38's legs and feet. The facility policy Skin Integrity dated 11/26/24, identified nursing staff would monitor resident's skin integrity and address issues promptly while providing care and services consistent with professional standards of practice.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview and document review, the facility failed to provide timely assistance with repositioning for 1 of 2 residents (R4); and failed to follow pressure ulcer treatments as ordered to promote healing for 1 of 2 residents (R31) reviewed for pressure ulcers Findings include: R4: R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 was cognitively intact and had diagnoses that included peripheral neuropathy (occurs when the nerves located outside of the brain and spinal cord are damaged. It often causes weakness, numbness, and pain, typically in the hands and feet, but can also affect other areas and body functions. It is common in people with diabetes.), type 2 diabetes, congestive heart failure (CHF), venous insufficiency (occurs when the valves in the veins become damaged, allowing blood to flow backward.), and dermatitis. R4 was at risk for pressure ulcer but had no open areas. R4's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 4/16/24, identified R4 was at risk for pressure ulcer/injury and pressure ulcer/injury would be addressed on R4's care plan. However, the CAA failed to identify an analysis of the findings. R4's Braden Scale for Predicting Pressure Ulcer Risk dated 1/3/25, identified R4 was at risk for pressure ulcer and did not include any interventions. R4's care plan revised 11/22/24, included an intervention of encouraging R4 to repositioning every two hours, and lay in bed to offload During a continuous observation on 2/26/25 at 8:26 a.m., nursing assistant (NA)-A and NA-G exited R4's room after assisting R4 with morning cares. R4 was sitting in her wheelchair. - At 8:31 a.m., R4 propelled her wheelchair to the dining room for breakfast. - At 9:16 a.m., R4 was finished with her breakfast meal and propelled her wheelchair to the activity room. No staff offered to reposition R4. - At 11:48 a.m., R4 propelled her wheelchair from the activity room to the med chart then propelled her wheelchair to common area off the dining room to watch tv. No staff offered to reposition R4. During an interview on 2/26/25 at 11:55 a.m., R4 stated she got up about 8:00 a.m. for breakfast and then went to the activity room for bible study. R4 was supposed to lay down or sit in her recliner every couple of hours. However, on 2/26/25, R4 had not laid down or sat in her recliner nor had staff offered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with NA-A and NA-G on 2/26/25 at 11:58 a.m., NA-G stated R4 was at risk for pressure ulcers, but the wound was healed right now. Staff were supposed to offer repositioning every two hours to try to prevent the area re-opening. NA-G stated NA-G nor NA-A had offered repositioning because it had just been one of those days. During an interview on 2/26/25 at 12:07 p.m., registered nurse (RN)-A stated staff were to encourage R4 to reposition every two hours to prevent pressure ulcers. During an interview on 2/27/25 at 3:37 p.m., the director of nursing (DON) stated staff were expected to offer repositioning per the resident's care plan. R4 was at risk for skin breakdown and staff were expected to keep R4 clean and dry. 41575 R31: R31's quarterly MDS dated [DATE], identified R31 had intact cognition and required partial assistance with dressing. and bed mobility, and was dependent with toileting and bathing. R31 was at risk for pressure ulcer development and had one facility acquired stage two pressure ulcer and one facility acquired stage four pressure ulcer present. R31 also had one stage two pressure ulcer that was present on admission. R31's diagnoses included congestive heart failure, and diabetes. R31's careplan dated 11/25/24, identified R31 had actual impairment to skin integrity of the left back calf and right heel related to deep tissue injury. Interventions included to elevate left leg so the wound would not touch the bed, float heels, use lambs wool under legs and feet, turn and reposition every two to three hours, and observe skin daily with cares, R31's Order Summary Report dated 2/27/25, directed staff to complete daily monitoring and documentation every shift for pressure ulcers located on right heel, left ankle and left mid calf. Physician ordered right heel wound care and left calf wound care included to remove wound dressing to both wounds, irrigate the wounds with sterile water, pat dry, apply a woven gauze wet to dry dressing and wrap both wounds with rolled gauze daily. On 2/25/25, at 3:03 p.m. registered nurse (RN)-A entered R31's room after putting on a gown, gloves and mask. RN-A laid out the necessary supplies to complete R31's ordered wound care on a disposable pad on R31's bed stand. RN-A uncovered R31's leg and proceeded to remove the dressing on R31's left calf. The dressing was dated 2/23/25 with black marker, two days before. Gauze packing was removed from the wound and was saturated with dried, serosanguinous drainage. RN-A irrigated the wound with sterile water and applied the wet to dry gauze and rolled gauze as ordered, dating the new dressing 2/25/25. After changing gloves, RN-A lifted R31's right leg up to assess his right heel. The heel was open to air, dry appearing serosanguinous drainage covered an eight inch area of the fitted sheet on the foot of the bed. A rolled gauze and folded gauze dressing was loosely wrapped around R31's right calf and was dated 2/23/25. RN-A cut off the old dressing that had slid up from R31's right heel wound. No drainage was visible on the old dressing. RN-A irrigated the right heel wound and applied the new dressing as ordered and dated the dressing 2/25/25. RN-A stated R31 must not have gotten his dressing changed the day before as ordered. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's Treatment Administration Record (TAR) for February 2025, identified monitoring and documentation of right heel, left ankle and left mid calf pressure ulcers were not signed off completed on February 17, 19, 20, 22, and 25. Physician ordered daily dressing change to right heel had not been signed off completed for February 21, 22, and 25 Physician ordered daily dressing change to left calf had not been signed off completed on February 17,19, 20, 22, and 25. When interviewed on 2/27/25, at 9:28 RN-F stated if an order on a resident's TAR was not initialed she would assume that to mean it had not been done that day. During interview on 2/27/25, at 9:44 a.m. RN-B stated if an order on a resident's TAR was not initialed off it could mean it had not been done. R31's dressings needed to be completed daily so they could monitor for symptoms of infection and drainage and make sure his wounds were not getting any worse. During interview on 2/27/25, at 2:12 p.m. the DON stated she expected R31's dressings to be completed daily as ordered to help R31's wounds heal and prevent infection. The facility policy Skin Integrity dated 11/26/24, identified the facility would assess each resident's risk for skin integrity issues at move in, quarterly, with any significant change in condition, and with a new or potential pressure ulcer and will identify interventions to help prevent skin integrity issues. Residents at risk for skin breakdown would have preventative measures implemented such as repositioning plan and pressure redistribution devices. The Care plan would address the resident needs, goals, and interventions based on the skin assessment and resident/representative input. Interventions will be implemented, reviewed, and updated for appropriateness. Further, pressure ulcers would be observed daily. Documentation would include evaluation of the pressure ulcer, evaluation of the status of the dressing, status of the surrounding area, presence of complications and pain if present.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on observation, interview, and document review, the facility failed to comprehensively assess each fall to ensure interventions were followed; and failed to ensure fall interventions were care planned timely and implemented to prevent falls for 1 of 1 residents (R19) reviewed for falls. Findings include: R18's significant change Minimum Data Set (MDS) dated [DATE], identified R18 had a severe cognitive impairment and diagnoses that included Alzheimer's disease, dementia and osteoporosis. R18 had a fall without injury and a fall with injury. R18 did not use an alarm or any physical or electronic device that monitored R18's movement and alerted staff when movement was detected. R18's Falls Care Area Assessment (CAA) dated 1/6/25, identified R18's fall risk was 27; Score 10 or higher indicated R18 was at high risk of falls. R18 was currently assistance of one staff for all transfers with the use of a mechanical lift. R18 was not able to walk, was using a manual wheelchair. R18 was able to move herself around short distances in the wheelchair and was staff assist of 1 for longer distances. R18 often attempted standing independently, staff were monitoring her closely to intervene and prevent falls. OxyCODONE HCl (narcotic pain medication) Oral Tablet 5 miligram (MG) Give 0.5 tablet by mouth every 4 hours as needed for moderate to severe pain related to CELLULITIS OF RIGHT LOWER LIMB was Prescribed by when in hospital and R18 was currently taking it. The CAA identified R18's Falls - Functional Status would be care planned but provided no further information. R18's care plan revised 2/6/25, identified R18 was at risk for all related to confusion. Interventions included: - Assist R18 as needed with mobility and transfers - Be sure R18's call light was within reach and encourage R18 to use it for assistance as needed. - Bed in lowest position - Ensure that R18 was wearing appropriate footwear shoes when up ambulating or mobilizing in wheelchair and gripper socks when in bed. - R18 did not remember that R18 needed assistance with transfer or ambulation, anticipate needs. - R18 had a Bed sensor on R18's wall. - R18 had an easy touch call light under sheet, under R18's hip on R18's bed. - R18 needed a safe environment with floors free from spills and/or clutter; personal items within reach, gripper strips on floor in front of bed, recliner, and toilet - Keep R18 wheelchair next to R18 during meals and activities (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R18 fall risk would be assessed every quarter and with change in condition However, the care plan failed to identify toileting as an intervention. R18's Incident Forms identified the following: - 11/7/24 at 8:45 a.m., identified R18 was heard yelling out for help, she was found lying on the floor in the hallway off the dining room. R18 was laying on the floor, laying on her right side. R18 stated she was walking to eat, and her knees just gave out and she fell to her knees and then fell to her right side. R18 would have been in bed three hours prior to fall. At 7:30 a.m., staff walked resident out to the dining room for breakfast. R18 was evaluated in the emergency room . Fall interventions included: physician reviewed medications, continue with present care plan, staff to offer to assist back to room when done with meals. However, the care plan was not revised to reflect this. - 11/15/24 at 3:00 p.m., R18 was laying against the entry door. Her walker was tipped over and laying against the door as well. R18's closet doors were both open and a pair of pants, still on the hanger were laying on the floor. R18 had her shoes on her feet. R18 stated that she was trying to get clothes to go in the bathroom and change. R18 was incontinent at the time of the fall. Vitals were taken and R18 was assessed. R18 does have a small hematoma on the back of her head. No other visible injuries and R18 did not have any complain of pain or discomfort. R18 was last toileted at 11:30 a.m.(3.5 hours prior). R18 was alert and oriented to her baseline, making jokes about falling on the floor. ROM was normal in both upper and lower extremities. Resident will be reviewed at the next High-Risk meeting. Fall interventions included toilet every two hours and follow care plan. However, the care plan was not revised to reflect this. - 11/22/24 at 1:15 a.m., identified a loud scream was heard and then a crash. R18 was found almost up against the door. Staff had to push the door open until staff could fit through. Stepped over R18's walker. R18 was sitting up against her closet and was confused. R18 stated she was just getting up. R18 did say she hurt everywhere. A quick exam was done. R18 asked to be put back to bed. When R18 was put in bed, the nursing assistant noted a big, black bruised lump on R18's right inner shin. R18 continued to say she hurt everywhere. Vitals were obtained while phones calls where made to R18's son. R18 was sent to the ER for evaluation. Fall intervention included a flat sensor placed under sheet under hip. However, the care plan was not revised to reflect this until 12/3/24. - 11/22/24 at 11:40 p.m., identified R18 was found lying on her left side next to her bed. Her head was positioned near the bed and her feet were towards the middle of the room. R18 had a UTI and is being treated with Cefdinir (an antibiotic) 300 miligram (mg) twice a day for 10 days. R18 had several falls recently and did have bruises from said falls. Palpated R18's head and did not find any lumps, bumps, or sore areas. R18 did have redness to left hip area. R18 denied any new pain but with dementia diagnosis R18 was not a reliable reporter/historian. R18's fall will be followed up at next High Risk Committee meeting. The Incident Form also identified staff were unsure sensor alarm was working due to no staff at the nursing station. Fall interventions included to place flat sensor under sheet under hip on bed. Referred to maintanence to order. However, the care plan was not revised to reflect this until 12/3/24. (continued on next page)

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 02/27/2025
NAME OF PROVIDER OR SUPPLIER: Littlefork Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 912 Main Street Littlefork, MN 56653	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/22/24 at 10:10 p.m., identified staff heard yelling and found R18 on the floor lying between closet and dresser with head close to the wall/feet pointing toward her bed. R18 was on her right side with her legs positioned under her wheelchair. R18 had right shoe on/left shoe off. Resident has dementia and was unable to tell staff what she was doing/where she was going. R18 reported that she hit her head. No bumps, lumps or sore areas found on her head. She c/o rt hip pain while on the floor but denied pain when in bed. However, the form failed to identify interventions implemented or if staff failed to follow the care plan. - 1/31/25 at 4:11 p.m., R18 sat herself up on the edge of her bed without staff assistance and no shoes on. R18 slid from the edge of her bed to the floor with her back to the bed. Nursing assistant was rounding on residents and found R18 sitting on the floor with her back to the bed. R18 was sitting there looking as though she sat there and was just leaning against the bed. R18 had socks on her feet and no shoes on. When asked what happened R18 stated, I was sitting on the edge of the bed and slid right of onto my butt, the bed was slippery and I didn't have my shoes on, so my socks were slippery too. Resident was assessed no Injuries noted. However, the form failed to identify interventions implemented or if staff failed to follow the care plan. During a continuous observation 2/26/25 at 9:38 a.m., R18 was assisted to lie down in bed by nursing assistant (NA)-A. NA-A did not offer toileting to R18. During an interview on 2/26/25 at 9:41 a.m., NA-A stated she did not offer toileting to R18. R18 was usually pretty continent and would say if R18 needed to use the toilet. During an interview on 2/27/25 at 11:06 a.m., NA-G stated R18 was a fall risk. R18 had a sensor in her room that told them when R18's moving and also has a touchpad call light that staff tucked under R18's side when R18 was in bed. R18 was pretty continent and did not go very often so staff did not toilet R18 every two hours. During a phone interview on 2/27/25 at 12:02 p.m., registered nurse (RN)-D stated R18 was a fall risk. R18 had a sensor on the wall in her room that told staff whenever there was movement in the room. R18 also had a touchpad call light on her mattress so if R18 tried to get out of bed it would let staff know. R18 needed to be toileted every two hours. R18 could tell staff too but R18 needed to be toileted every two hours. R18 hasn't tried to get out of bed since she came back from the hospital but R18 still had the sensors in her room. During an interview on 2/27/25 at 12:55 p.m., RN-F stated when a resident fell , an incident report was completed during the High Risk meeting, then RN-E updated the resident's care plan. R18 was a fall risk. R18 needed toileting every two hours and was able to tell you if R18 needed to go but needed help getting to and from the toilet. Staff should always offer toileting. RN-E stated R18 had memory loss and R18 might not think of it in time. It was safer for R18 to toilet, especially before lying down, because R18 wasn't waking up and trying to get out of bed. R18 did not always remember to use her call light. During an interivew on 2/27/25 at 1:09 p.m., RN-E stated R18 was at risk for falls and R18's care plan was not revised to reflect toileting every two hours and/or for staff to assist R18 back to her room after meals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/25 at 3:38 p.m., the director of nursing (DON) stated staff were expected to revise resident care plans with identified fall interventions and were expected to follow the care plans to attempt to prevent further falls. A facility policy regarding fall prevention was requested but not received.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to comprehensively assess for trauma informed care and identify potential triggers, to avoid potential re-traumatization for 1 of 1 residents (R7) reviewed for trauma informed care. Findings include: R7's quarterly Minimum Data Set (MDS) dated [DATE], identified R7 was cognitively intact and had diagnoses of post traumatic stress disorder (PTSD), anxiety, insomnia, and bipolar disorder (a mental illness characterized by extreme mood swings). R7's psychosocial well-being Care Area Assessment (CAA) dated 3/25/24, failed to identify an analysis and/or goal. R7's Social Services Quarterly Note dated 12/9/24, identified R7 had no change in status. R7 was currently receiving psychoactive medications and psychological/psychiatric services were currently indicated. R7's Behavior assessment dated [DATE], identified R7 became very upset with staff and aimed her anger toward one staff person, yelling at them, calling them names and refusing them to provide R7 with care. R7 was known to refuse cares which put R7 at risk for skin break down due to being incontinent of both bladder and bowel. These behaviors were caused by R7 feeling she was not being listened to or respected. Staff were directed to provide 1:1 time, conversation and change in caregivers. Leave room when R7 upset and calmly reapproach R7 later. R7's care plan revised 1/17/25, identified R7 had a behavior problem requesting task from staff, then refused when staff attempted to provide related to anxiety and depression. The following interventions were identified: - Two staff at all times when in R7's room. - Ask R7 if there was anything R7 needed/reason for calling out/disruptive noises. - Anticipate and meet R7's needs. - Document in tasks that were completed or refused. - Document outside R7's room the time you enter/leave room - Explain all procedures to R7 before starting and allow R7 to adjust to changes. Tell R7 going change her, reposition or when need to touch R7 with cares. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R7 was either elated or upset not happy with anything when R7 asked for assist. Then will refuse to allow staff to assist R7. R7 yelled with cares, will make false statements of abuse by staff. Requested for staff numerous times to R7 room, then wanting them to come back later. R7 wanted instant gratification. - If reasonable, discuss R7's behavior. Explain/reinforce why behavior was inappropriate and/or unacceptable. - Leave and return later to complete R7's cares - Leave R7 alone to calm down when R7 was yelling/screaming at staff. Once had calmed down return to address any concerns. However, the care plan failed to identify R7's PTSD triggers and/or interventions specific to his PTSD. R7's medical record failed to identify a Trauma-Informed Care Assessment was completed. During an interview on 2/26/25 at 1:55 p.m., the activities director (AD) stated she was the facility social worker. AD stated R7 did not have a Trauma Informed Care Assessment in her medical record. AD had recently learned that she was responsible to complete that assessment and had done so for another resident. The purpose of the assessment was to let the facility staff know of a history of abuse, any traumatic events in a resident's life that could potential trigger a memory or event or unwanted care. Basically to be aware of things that could be not good or unpleasant for a resident. R7 had a history of childhood sexual abuse. AD stated R7's care plan did not identify R7 had PTSD nor did the care plan identify triggers that could be unpleasant for R7 such as a male caregiver. During cares, especially during pericares, staff had to be diligent to tell R7 what was going to hapen. A second person was always in the room because R7 had a history of false accusations towards staff. During an interview on 2/27/25 at 3:30 p.m., the director of nursing (DON) stated a Trauma Informed Care Assessment should be completed because it ensured staff individualized treatment for R7 and also ensure R7 received the extra care and services R7 might need The facility policy Trauma Informed Care revised 9/11/23, identified the facility would ensure residents who are trauma survivors receive culturally competent, trauma informed care in accordance with professional standards of practice. The procedure directed the following: A. The care center will use a multi-faceted approach to identify a resident's history of trauma through: a. Admission assessment, including a screening tool for trauma, by interviewing the resident and/or their representative b. History and physical c. Social history and assessment d. Review of medical records (continued on next page)

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	02/27/2025

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

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Interview of primary care physician f. Observation of behaviors that may indicate past trauma B. Care centers will use a universal screening tool to identify previous trauma emphasizing the value of culture and diversity of others. a. The screening tool for trauma will be completed as an assessment in the electronic medical record (Trauma-Informed Care: Resident/Trauma-Informed Care: Responsible Party) by Social Services (or designee) with the resident and/or their representative on admission or when behaviors may indicate past trauma. C. Care planning of resident centered behavioral health approaches and goals will be completed in response to the screening or when identified on periodic assessment of resident survivor. Care plan goals and approaches will include individual preferences and routines in response to the emotional and psychosocial needs of the resident survivor. D. If trauma is identified within 48 hours of admission, interventions will be added to the baseline care plan to address the trauma until completion of the comprehensive care plan. E. The interdisciplinary team will ensure that the resident survivor receives appropriate services and treatments. Community resources will be utilized as needed. F. Trauma Informed Care competency training will be completed upon hire and annually with all staff providing services to resident survivors.

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F 0732

Level of Harm - Potential for minimal harm

Residents Affected - Many

Post nurse staffing information every day.

40943

Based on observation, interview and document review, the facility failed to ensure a posting was updated daily and ensure the census was on the nurse staff posting. This had the potential to effect all 38 residents residing in the facility and/or visitors who may wish to view the information.

Findings include:

During an observation on 2/21/25 at 1:06 p.m., the facility nurse staff posting was on the wall near the front entrance. The nurse staff posting was dated 2/21/25, indicated a census of 38 and included information on scheduled shifts for nursing staff along with the number of staff assigned to the shift with total hours worked.

During an observation on 2/25/25 at 3:17 p.m., the nurse staff posting continued to be dated 2/21/25. The director of nursing (DON) stated she did not know who was responsible to complete, update and post the nurse staff posting.

The nurse staff postings were reviewed from 1/19/25 through 2/25/25. The nurse staff postings were not updated with actual working staff hours on the following 12 days: 1/19/25, 1/20/25, 1/23/25, 1/24/25, 2/1/25, 2/2/25, 2/3/25, 2/15/25, 2/16/25, 2/17/25, 2/20/25 and 2/21/25.The facility census was not recorded on the following 26 days: 1/21/25, 1/22/25, 1/25/25, 1/26/25, 1/27/25, 1/28/25, 1/29/25, 1/30/25, 1/31/25, 2/4/25, 2/5/25, 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/10/25, 2/11/25, 2/12/25, 2/13/25, 2/14/25, 2/18/25, 2/19/25, 2/22/25, 2/23/25, 2/24/25, and 2/25/25.

During an interview on 2/25/25 at 3:24 p.m., the DON stated night shift staff were responsible to complete the nurse staff posting and each shift's nurse was responsible to update the posting to reflect staffing changes, which was not consistently being done. Staff were expected to ensure the completion and posting of the nurse staff posting and update the nurse staff posting throughout the day to reflect staffing changing because it was for resident and/or visitors use.

The facility policy Nursing Staff Posting undated, identified the following:

1. The Night Charge Nurse will count daily the number of nursing staff directly responsible for resident care.

2. The information will indicate the number of RN's, LPN's, and NAR's working on each shift for the day.

3. It will also include the facility census at the start of the day.

4. The information will be updated as needed in response to call-in, traded shifts, absences, etc.

5. Census information will be updated as needed with admissions and discharges.

6. The information will be posted by the main entrance.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	7. Previous postings will be kept in the Medication Room. 8. The information will be kept for eighteen (18) months.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and document review, the facility failed to assess dementia related behaviors and implement appropriate interventions to minimize verbal and physical resident to resident altercations for 1 of 2 residents (R22) reviewed for dementia care. Findings include: R22's admission Minimum Data Set (MDS) dated [DATE], identified R22 had severe cognitive impairment and required supervision with activities of daily living (ADLs). R22 exhibited delusions, physical and verbal behaviors symptoms directed toward others daily, as well as other behavioral symptoms such as pacing, rummaging and verbal symptoms. R22's behavioral symptoms significantly impacted his care as well as put others at significant risk for physical injury, intruded on their privacy and disrupted care and living environments. R22 rejected care and wandered daily. Diagnoses included neurocognitive disorder with lewy bodies, and heart disease. R22's Behavior Care Area assessment dated [DATE], identified R22 had a diagnosis of lewy body dementia and was very paranoid. R22 verbally threatened to kill other residents, staff and his wife. R22 pushed and hit staff. R22 wandered continuously, was intrusive to other residents and staff and was difficult to redirect. R22 was on antipsychotic, antidepressant and antianxiety medications. R22's Cognitive Loss/Dementia Care Area assessment dated [DATE], identified R22 had severe cognitivie impairment and a diagnosis of lewy body dementia with behaviors. R22's care plan revised on 2/17/25, identified a focus R38 would not harm self or others with a goal R38 would remain safe. Interventions included to approach him by his side when upset, do not talk about his wife or tell him no. If poses a threat to injure self or others, staff were to notify provider and approach with one to two persons calmly, from his side and call by name. maintain a consistent schedule, minimize environmental stimuli, monitor for factors that may contribute to violent behaviors, remove from conflict with other residents and utilize diversional techniques such as 1;1, short word sentences, take for a walk or offer an activity. Another focus on the care plan was behaviors problems physically aggressive to staff evidence by pushed, grab, yell, shake fist or abrupt approaches. Staff were to utilize the same interventions as well as explain procedures before starting, get help from other staff when necessary, monitor behaviors to attempt to determine underlying cause, redirect with distraction such as food., and intervene immediately during any negative interaction R22 was involved in. R22's care plan failed to identify his behaviors toward other residents in the facility or directed interventions to address the resident to resident incidents when they occurred. During observation on 2/24/25, at 5:55 p.m. R22 was pacing in the halls and dining room in an hurried manner, pushing at staff who were walking along with him. Two unidentified staff attempted to get R22 to return to his room without success and stopped when R22 struck out and pushed them away. An unidentified staff member dressed in gown, gloves and mask stayed beside R22 as he paced around residents in the dining area. At 6:18 p.m. R22 sat with the staff member, at a table in dining area eating a snack. (continued on next page)

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 02/27/2025

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F 0744

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Residents residing in the facility identfied the following concerns related to R22's behaviors:

During interview on 2/24/25, at 1:30 p.m. R38 stated R22 had entered his room and woke him up in the early morning, taking things off his table. R38 stated if you tried to stop R22 from taking items R22 got mad. R22 would ball up his fist like he was going to punch but he never had. Staff had been chasing after R22 and came in behind him and got him out of R38's room. R38's admission MDS dated [DATE], identified R38 had intact cognition.

When interviewed on 2/24/25, at 2:54 p.m. R36 stated R22 would chase female staff and residents. R22 had chased them down the hall waving a four footed cane at them. R22 tried to shake that cane at R36 on one occasion., when R36 walked by R22 and noticed R22 had dropped his cookies, so R36 retrieved the cookies and handed them back to R22. R22 became mad and bunched up his fist, threatening to punch R36. R36 stated he just took his cane and held R22's arm against his chest with it and told him not to threaten to punch him and then changed the subject to distract him. R36's admission MDS dated [DATE], identified R36 had intact cognition

During interview on 2/25/25, at 11:13 a.m. R28 stated R22 did not like her and every time he saw her he would shake his fist at her and threaten to punch. R28 though it was because she always hollered at R22 to get out of her room when he wandered in. Once, she had shut her room door to keep him from getting in and he kicked and banged on her door angrily to try to get it back open. The facility had told her they were trying to find some where else for R22 to go. R28's quarterly MDS dated [DATE], identified R28 had intact cognition

R22's progress notes identified the following:

- 1/12/25, R22 walked up behind another resident sitting in a chair in the dining room and attempted to tip the chair backwards with the other resident in the chair. The resident hollered and told him to stop. R22 became agitated. Staff intervened and sat at the table with the residents until they calmed down.

- 1/19/25, R22 was approached by another male resident who leaned down and punched R22 in the stomach. R22 then punched the male resident back. Staff were present and separated the residents.

- 2/4/25, R22 stated he was knocking on another resident's door when she opened it and slammed it, yelling at him, and the door hit R22 in the nose. This made R22 angry and he started kicking at the door.

- 2/8/25, R22 had been going up behind other residents that are in wheelchairs and pushing them in the hallway, which made the other residents upset.

- 2/11/25, R22 was confrontational with a male resident he had a previous altercation with. Staff intervened before anything could occur.

- 2/15/25, R22 was wandering and difficult to redirect. R22 continued to get into other male residents faces as if trying to fight them, and getting into yelling matches. Gets mad at staff, yells and shakes fist with any attempt to redirect him.

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	245542	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 2/16/25, R22 approached another resident and took his cane. Became agitated when staff attempted to get the cane back. R22 approached another male resident who was on the phone. R22 hovered over the resident hollering at him for sitting in the chair. The unidentified resident became very upset and verbalized he did not want R22 near him. R22 became more agitated with staff attempts to redirect him. Eventually R22 moved away, however, returned again two minutes later with the same outcomes. - 2/20/25, R22 wandered the halls and entered other resident rooms. R22 was near the entrance door when another resident entered from smoking outside and began to shout at R22. R22 became upset and shook his fist at the other resident. R22 was redirected away without incident. - 2/21/25, after a confrontation with another resident, R22 became very agitated, kept showing his fist and stated She is nuts. I'm going to show her. I'm going to knock her right out. - 2/22/25, R22 woke at 1:30 a.m. and was wandering into other resident rooms. - 2/22/25, R22 was pacing the halls and going in and out of other resident rooms, which was upsetting the other residents who were still in bed. - 2/22/25, R22 had a pocket full of another residents markers that he had picked up from the activity room. The resident followed R22 to get the markers back until staff redirected the residents away from each other. - 2/23/24, R22 pushed a resident that was in her wheelchair and when asked to stop would not listen and continued to push the resident down the hall. R22's medical record lacked a comprehensive behavior assessment to address types of behaviors, triggers, a review of interventions that worked or did not along with resident to resident incidents inlcuding person centered specific interventions to limit the behaviors. During interview on 2/25/25, nursing assistant (NA)-F stated when R22 appears agitated the staff walk with him and give him one to one. R22 would shake his fist at other residents and when staff see him doing that they separate them. They usually could redirect R22 away with diversional conversation. NA-F was not aware if R22 had actually hit another resident. A joint interview was conducted with registered nurse (RN)-B, RN-C and the director of nursing (DON) on 2/25/25, at 4:49 p.m. RN-B stated R22 had not been feeling well or eating well that week and so had remained in his room. R22 had threatened other residents by shaking his fist at them and getting in their personal space, but she thought that was improved. The DON stated since the facility had gotten his psychotropic medications adjusted R22 has shown improved behavior. Now when approached by staff when he is angry and shaking his fist, he will say I do not want to hit you, or when he sees R28, who frequently hollers at him, he will say I need to stay away from that one. R22 was showing more awareness of his behaviors. RN-C felt resident to resident incidents were decreasing and when the other residents ignored R22, he walked right by, but some of the residents were super vigilant towards R22 and escalated the behaviors. RN-C stated some of the residents were over anxious because of past behavioral incidents and scared because they were vulnerable. R22 had a friend visit him and when the friend saw R22 had a male roommate the friend approached staff and reported R22 does not really get along with roommates, and so we moved the roommate to another room as a precaution. (continued on next page)

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	02/27/2025

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

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 2/26/25, licensed practical nurse (LPN)-A stated R22 could be a handful. R22 did not know boundaries and would get into others faces and the other residents, especially the male residents, did not like that. The staff kept an eye on him when he was out of his room and provide one to one supervision when agitated. LPN-A did not think other residents were afraid of R22, just irritated as he gets right in your face and does not have any boundaries. During telephone interview on 2/26/25, at 12:09 p.m. RN-D stated she had worked when R22 had pushed R down the hall in her wheelchair.R22 liked to push things. When R22 was restless or agitated RN-D tried to talk with him and talk him down. RN-D thought R22 listened to her as it was in the way he was approached. R22 did not respond well to loud voices. RN-D felt R22 really needed one to one supervision and should always have someone with him. There was just not enough staff to provide one to one to him all the time. R22 will make comments he is going to punch a resident or hit them and would even make comments like I am going to kill you. His words are jumbled up though and the other residents frequently would not understand him and just tell him to get away from them. During telephone interview on 2/27/25, at 2:48 p.m. the medical director (MD)-D stated he had not been notified of any of R22's resident to resident interactions. He had gotten calls to refill R22's PRN lorazepam when the primary physician was not available. He would not expect the facility to call him with resident behaviors even if other residents were involved or affected. MD-D expected the facility to call the primary physician and the primary could adjust the resident's medications or send him to the emergency room to be evaluated. The only time MD-D would expect a call from the facility is if the primary physician could not be reached. The facility policy Dementia Care with revision date 4/5/16, identified a comprehensive assessment of each resident would be completed on admission. The assessment would include usual cognitive patterns, mood and any behavioral distress associated with dementia the resident has had in the past, what behaviors have occurred and their possible underlying causes, and approaches that calmed the resident once they became distressed. If a resident appeared to be distressed, staff would describe the specific experience and implement non-pharmacological approaches according to the identified cause. Staff would evaluate whether the cognitive patterns, mood or behaviors present a risk to the resident or others and in collaboration with the practitioner, identify risk and underlying causes for the resident's distress related behaviors. If the resident had behaviors that appeared to be distress- related, the care plan would reflect an individualized approach with a description of potential distress triggers and nonpharmacological approaches to implement when distress is expressed or indicated.

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 02/27/2025
NAME OF PROVIDER OR SUPPLIER: Littlefork Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 912 Main Street Littlefork, MN 56653	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on interview and document review, the facility failed to ensure the consulting pharmacist recommendations were addressed and acted upon and documented in the medical record for 3 of 5 residents (R11, R22, R36) reviewed for unnecessary medication use. Findings include: R11: R11's admission Minimum Data Set (MDS) dated [DATE], identified R11 had severe cognitive impairment and diagnoses included Alzheimer's disease and malignant neoplasm of rectal sigmoid junction. R11's Order Summary Report dated 2/17/25, identified R11's current medication regimen with their corresponding start dates. This included an order for quetiapine (an antipsychotic) 25 mg one tablet at bedtime related to dementia with other behavioral disturbances with order date 11/26/24. R11's completed Consultant Pharmacist's Medication Review, dated December 2024, identified R11's medication regimen was reviewed and an irregularity was listed involving R11's medication quetiapine with related to the indication for the medication was listed as dementia with anxiety and no behavioral disturbance. The suggested course of action identified it was prudent to verify the accuracy for low dose quetiapine as these sometimes were not appropriate to continue. Please verify the indication accuracy. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it and providing a rational and the resident was on the lowest effective does. The review was requested for . ASAP [as soon as possible] but no later than 30 days. R11's medical record lacked evidence the consulting pharmacist's recommendation on R11's quetiapine dose irregularity had been forwarded, reviewed and/or acted upon by the physician. When interviewed on 2/27/25, at 2:12 p.m. the director of nursing (DON) stated a dementia diagnosis was not enough to prescribe quetiapine and she planned to speak with the provider regarding the issue. During telephone interview on 2/27/25, at 12:54 p.m. the consulting pharmacist (CP)-E stated she made a recommendation in December dementia was not an appropriate diagnosis to prescribe quetiapine. When CP-E had spoken with the DON she had been told everything was addressed by the physician in January, then it was discovered it had not been. During telephone interview on 2/27/25, at 3:29 p.m. R11's primary provider (DR)-A stated when the medication is ordered, a diagnosis pops up and he had chosen it. DR-A was not aware of the regulations and nobody had brought the issue up to him when he conducting rounds at the facility. DR-A did the medical rounds and the mental health practioner nurse practioner (NP)-F did the mental health rounds. NP-F would be more aware of the regulations regarding those medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25, at 4:01 p.m. NP-F was called with a request for a return call, however, none was received. R22: R22's admission MDS dated [DATE], identified R22 had severe cognitive impairment and diagnoses included neurocognitive disorder with Lewy bodies dementia. R22's Order [NAME] Report dated 1/12/25, identified current medication regimen with their corresponding start dates. Including the following as needed (PRN) orders: -quetiapine 25 milligrams (mg) by mouth (po) every 24 hours as needed for anxiety/agitation. Start Date of 1/10/25, with no end date ordered. R22's Order Summary Report dated 2/3/25, identified current medication regimen with their corresponding start dates. Including the following as needed PRN orders: -haloperidol injection 5mg/milliliter (ml) inject 0.5 ml intramuscularly (IM) every hour PRN for agitation/aggressive behaviors related to neurocognitive disorder with lewy bodies. Start date of 1/22/25, with no end date ordered. -lorazepam injection 2 mg/ml inject 0.5 ml IM as needed for agitation. May have up to two doses daily after 30 minute interval. Start date of 1/22/25, with no end date ordered. -lorazepam 1 mg by mouth (po) every four hours PRN for agitation and aggression. Start date 1/19/25, with no end date ordered. -olanzepine 5 mg tablet, give one tablet every 12 hours PRN for agitation related to neurocognitive disorder with lewy bodies. Start date of 1/22/25, with no end date ordered. R22's completed Consultant Pharmacist's Medication Review, dated January 2025, identified R22's medication regimen was reviewed and an irregularity was identified involving R22's PRN medication quetiapine with comment that PRN antipsychotic medications were limited to a 14 day duration based on CMS guidelines. When prescribing PRN antipsychotic's the medical record would include indication/clinical need, dose and frequency of use. If the treatment was to be extended after the initial treatment duration had ended, the resident must be re-evaluated and a new order provided each time. The suggested course of action listed was to re-evaluate the clinical appropriateness of the current therapy. Add a 14 day stop date to the antipsychotic and if the treatment was to be continued, to perform a clinical evaluation/examination of the resident and provide a new order as specified above after the initial 14 days. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on . ASAP [as soon as possible] but no later than 7 days. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen had been reviewed and irregularity was listed involving R22's PRN medication haloperidol injections with comment that R22 was admitting with an order for a PRN antipsychotic medication, however, there was no stop date/duration indicated on the order. Per CMS guidelines, PRN antipsychotic orders must be limited to a 14 days. Additionally, guidelines require a face to face provider evaluation, documentation of clinical rationale and a new order with a 14 day stop date to continue the PRN antipsychotic. The suggested course of action listed was to ensure all new PRN antipsychotic orders were accompanied by 14 day stop dates. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it it, it was requested to be followed up on . ASAP [as soon as possible] but no later than 7 days. R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen was reviewed and an irregularity was identified involving R22's PRN medication lorazepam tablet with comment PRN psychotropic such as lorazepam were limited to a 14 day duration based on updated CMS guidance and rules unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. When prescribing PRN psychotropics, the medical record should include the indication/clinical need, dose and frequency of use. If treatment was to be extended after the pintail treatment duration had ended, the resident must be re-evaluated and a new order provided. The suggested course of action listed was to reevaluate appropriateness of the continued therapy. If continued to add an appropriate stop date for the psychotropic medication and document duration of threaten and clinical evaluation/rationale of the resident. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it it, it was requested to be followed up on . ASAP [as soon as possible] but no later than 7 days. R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen was reviewed and an irregularity was identified involving R22's PRN medication lorazepam injection with comment PRN psychotropics such as lorazepam were limited to a 14 day duration based on updated CMS guidance and rules unless the prescriber chose to extend treatment by providing clinical rationale and documentation of intended duration. When prescribing PRN psychotropics, the medical record should include the indication/clinical need, dose and frequency of use. If treatment was to be extended after the pintail treatment duration had ended, the resident must be re-evaluated and a new order provided. The suggested course of action listed was to reevaluate appropriateness of the continued therapy. If continued to add an appropriate stop date for the psychotropic medication and document duration of threaten and clinical evaluation/rationale of the resident. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it it, it was requested to be followed up on . ASAP [as soon as possible] but no later than 7 days. R22's completed Consultant Pharmacist's Medication Review, dated February 2025, identified R22's medication regimen had been reviewed and irregularity was listed involving R22's PRN medication olanzapine with comment that R22 was admitted with an order for a PRN antipsychotic medication, however, there was no stop date/duration indicated on the order. Per CMS guidelines, PRN antipsychotic orders must be limited to a 14 days. Additionally, guidelines require a face to face provider evaluation, documentation of clinical rationale and a new order with a 14 day stop date to continue the PRN antipsychotic. The suggested course of action listed was to ensure all new PRN antipsychotic orders were accompanied by 14 day stop dates. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on . ASAP [as soon as possible] but no later than 7 days. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's Febuary Medication Administration Record (MAR) was reviewed 2/1/25 through 2/24/25 and identified R22 received PRN lorazepam daily and 12 of the 24 days had received the medication two to four times per day. R22 received the PRN olanzapine 14 times during that period. R22's medical record was reviewed and lacked evidence the consulting pharmacist's recommendation on R22's identified medication irregularities had been forwarded, reviewed and/or acted upon by the physician. During telephone interview on 2/27/25, at 12:54 p.m. the consulting pharmacist (CP)-E stated she had made a recommendation in January to make sure the provider completed a face to face evaluation and then every 14 days. When CP-E spoke with the DON she was told everything was addressed in January but during her review in February CP-E had to reissue her recommendations. That was when the DON discovered the recommendations had not been addressed by the provider. CP-E would have expected the provider to follow up on her recommendations within 7 days and they were not. When interviewed on 2/27/25, at 2:12 p.m. the DON stated she was aware antipsychotic and psychotropic medications needed to be evaluated within 14 days with a duration stop date and PRN antipsychotic medications needed to have a face to face provider evaluation.The DON was not sure what the facility's process was for obtaining the information needed to meet the requirement. The DON had given the pharmacist recommendations to another nurse to address with the physician she was not sure why they were not addressed. The DON stated she needed to do a better job following up on the pharmacy recommendation with her nurses. During telephone interview on 2/27/25, at 3:29 p.m. R22's primary provider (DR)-A stated he was not aware a face to face evaluation was required every 14 days when prescribing PRN antipsychotic medications. He did know R22 was very aggressive and had attacked staff. MD-A saw R22 two times since his admission and the nurses never mentioned the regulation. MD-A did the medical rounds and the mental health practioner nurse practioner (NP)-F did the mental health rounds. NP-F would be more aware of the regulations regarding those medications. On 2/27/25, at 4:01 p.m. NP-F was called with a request for a return call, however, none was received. R36: R36's admission MDS dated [DATE], identified R36 had intact cognition and diagnoses included general anxiety disorder, depression, chronic pain and bipolar disorder. R36's Order Summary Report dated 2/27/27, included the current medication regimen with their corresponding start dates. This included orders for clonazepam 1 mg in the morning and 0.5 mg at bedtime, diazepam 5 mg every 24 hours as needed for anxiety, hydrocodone-acetaminophen 7.5-325 mg every 8 hours as needed and hydrocodone-acetaminophen 7.5-325 mg every 8 hours for pain. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36's completed Consultant Pharmacist's Medication Review, dated December 2024, identified R36's medication regimen was reviewed and an irregularity was identified involving R36's medication diazepam with comment since the medication was used for a psychological condition and due to updated CMS regulations, the PRN medication had to be re-evaluated within the first 14 days of starting. If the medication was to be continued a re-evaluation date was needed. The suggested course of action listed was to add a re-evaluation date to re-assess, i.e., continue for 60 days then re-evaluate, etc. R36 was also taking another scheduled benzodiazepine, clonazepam two times per day. There was a potential for addictive effects and increased adverse reactions. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on . ASAP [as soon as possible] but no later than 30 days. R36's completed Consultant Pharmacist's Medication Review, dated January 2024, identified R36's medication regimen was reviewed and an irregularity was lidentified involving R36's medication hydrocodone/acetaminophen with comment R36 was at increase risk for CNS/respiratory depression due to the combined use of a benzodiazepine and an opioid analgesic. Hydrocodone/acetaminophen and clonazepam. The suggested course of action listed recommended re-assessing the use of the combination of medications. Please provide clinical rationale, for documentation purposes, the the current benefits outweigh the risks. However, there was no recorded response from the physician on either accepting this recommendation or rejecting it, it was requested to be followed up on . ASAP [as soon as possible] but no later than 30 days. R36's medical record lacked evidence the consulting pharmacist's recommendation on R36's benzodiazepam and opioid medications had been forwarded, reviewed and/or acted upon by the physician. A policy was not received for pharmacy reviews.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943 Based on interview and document review, the facility failed to ensure use of an as-needed psychotropic medication was limited to a 14-day period and/or re-evaluated by the provider to ensure ongoing need and efficacy of the medications for 2 of 5 residents (R18,R22) reviewed for unnecessary medication use. In addition, the facility failed to complete comprehensive assessment and ongoing monitoring of behaviors for an administered antipsychotic medication to ensure efficacy of the medication for 1 of 5 residents (R11) reviewed for unnecessary medication use. Findings include: R18: R18's significant change Minimum Data Set (MDS) dated [DATE], identified R18 had a severe cognitive impairment and diagnoses that included Alzheimer's disease and dementia. R18 did not exhibit behaviors during the assessment period. R18's undated care plan, identified R18 used anti-anxiety medications (lorazepam) related to recent changes in health status. Interventions included: - Administer anti-anxiety medications as ordered by physician. Monitor for side effects and effectiveness every shift. - Make referrals for me as needed - Monitor me for safety. I am taking anti-anxiety meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. - Monitor/document/report PRN any adverse reactions to anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations - Monitor/record occurrence of for target behavior symptom, inappropriate response to verbal communication, violence/aggression towards staff/daughter and document per facility protocol. - My non-pharmacological interventions include: 1: 1, Distraction/redirection, family visits. - Observe for changes in my behavior and update provider R18's physician order dated 1/16/25, identified lorazepam tablet 0.5 milligram (MG). Give one tablet by mouth every two hours as needed for anxiety or agitation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R18's electronic medication administration record (EMAR) dated January 2025, identified R18 received lorazepam on 1/29/25. R18's EMAR dated February 2025, Jan EMAR identified R18 received lorazepam on 2/11/25 and 2/21/25. R18's medical record failed to identify if a a face-to-face provider evaluation for continued use of a as needed (PRN) psychotropic medication was completed. R18's nursing progress notes identified the following: - 1/16/25 at 2:27 p.m., R18 was slightly declining for the past 48 hours. Concerns were discussed with family. Orders were obtained from the medical director (MD) to ensure R18 remained comfortable and had no anxiety/anxiousness. Lorazepam 0.5mg every 2 hours as needed and morphine sulfate 20mg/milliliter (mL), give 0.125mL every 2 hours as needed for severe pain/discomfort, and oxygen to maintain sats above 90% or for comfort. These medications should only be utilized if/when R18 was no longer safe to obtain oral pain medications. - 1/29/25 at 6:10 p.m., R18 was in the dining room sitting at her daughter's table and started yelling help me help me, I want to lay down. When approached, R18 started yelling that she needed to go to bed. Staff took R18 to her room and got her into her bed. R18 was not in her bed 10 minutes, and R18 began yelling that she wanted to get up. Staff got her up and then R18 started to say she wanted to lay down again. Staff would tell her that she needed to stay up for a while and that they could not keep laying her down and getting her back up. Staff was administered 0.5mg Ativan at 6:01 p.m. for anxiety. R18 was saying that her legs hurt, she did get her pain medication as scheduled at 5:50 p.m. R18 was sitting in the dining room and kept asking staff to lay her back down. - 2/11/25 at 3:58 p.m., R18 was lying in bed and started hollering help me, help me!! When staff arrived, R18 was flailing her arms and legs around and starting to dry heave. Staff was unable to get R18 to calm down, staff administered 0.5mg Ativan at 3:46 p.m., a warm blanket and sat by her bedside until R18 calmed down and fell asleep. - 2/21/25 at 12:46 a.m., R18 was yelling out non-stop. R18 insisted that she was laying on top of a car and the guys have to get her off. Staff spent 1:1, changed her brief, gave fluids and offered a snack. Staff was unable to redirect/reorient her. She declined snack, took in fluids but continued to yell out. R18 was anxious and teary, very agitated. As needed lorazepam 0.5 mg was given. Staff continued to reassure R18 that everything was okay. During an interview on 2/27/25 at 12:55 p.m., registered nurse (RN)-F stated she recently learned an as needed antipsychotic should be re-evaluated with a face-to-face provider visit every two weeks. I just learned that yesterday. RN-F stated R18's medical record lacked information identifying a face-to-face provider evaluation was completed. During a phone interview on 2/27/25 at 3:29 p.m., R18's physician (DR)-A stated he was unaware of the requirement to perform a face-to-face re-evaluation of antipsychotic PRN medications every 14 days and nursing did not inform him. 41575 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R11: R11's admission MDS dated [DATE], identified R11 had severe cognitive impairment and required moderate assistance with dressing, bathing, and toileting. R11 was identified to have wandering one to three times during the assessment period and did not exhibit physical or verbal behaviors toward others. R11's diagnoses included malignant neoplasm of the rectal sigmoid junction and thrombocytopenia. R11's care plan with revision date 12/24/24, identified R11 was at risk for elopement and wandering. Interventions included to provide a wander guard and structured activities such as toileting, walking, and reorientation strategies such as signs, pictures, and memory boxes. Use of psychotropic medications related to behavior management was also identified. Staff were instructed to administer medications as ordered, monitor for side effects, discuss with physician regarding ongoing need and indicated R11 was on a behavior management program, however, lacked documentation of what behaviors were exhibited and/or what the behavior management program entailed. The care plan further identified R11 at risk for insomnia with interventions to administer medications as ordered, maintain a consistent routine to retire and wake up and discourage daytime naps. R11's Order Summary Report dated 2/17/25, identified an order for quetiapine 25 mg one tablet at bedtime related to dementia with other behavioral disturbances with order date 11/26/24, gabapentin 250 mg/5ml give 1 ml three times per day related to dementia with other behavioral disturbances with order date 1/22/25, and escitalopram 2.5 mg every morning related to dementia with other behavioral disturbances with order date 12/18/24. Staff were directed to monitor for side effects related to the psychotropic medications. Target behaviors with order date 11/29/24, listed depression with non-pharmalogical approaches of one to one, distraction, calm approach and offer food/drink every shift. Staff were to record if behaviors had been observed or not observed. R11's Order Summary Report dated 2/26/25, identified R11's gabapentin was increased from 1 ml three times per day to 1.5 ml three times per day with start date 2/24/25. The medical record lacked an assessment to support the increase in gabapentin. R11's MAR for February 2025, identified the medication quetiapine, gabapentin and escitalopram was administered every day 2/1/24 through 2/26/25, as ordered. Target behaviors were not monitored on the February 2025, MAR. On 2/25/25, at 11:20 a.m. R11 was observed standing with walker in his room doorway, fully dressed in preparation to go to the dining area for lunch. When staff attempted to redirect R11 back into room, R11 stated no he did not want to eat in his room. R11 was assisted to put on a face mask and assisted to the dining area. R11 remained seated alone at the dining room table, removing his mask only to eat and then returned to his room. On 2/26/25, at 11:36 a.m. R11 was observed seated in a recliner in his room. R11 was seated quietly in his room. There was no television in room and/or magazines visible nearby. R11 watched as staff and residents passed by the room and occasionally would holler out a greeting and/or smile and wave. (continued on next page)

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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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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint interview was conducted on 2/27/25, at 9:13 a.m. with nursing assistant (NA)-A and NA-H. NA-A stated she was not aware R11 had any behaviors. R11 could sometimes act a little grumpy or anxious but liked to joke around and would soon come out of it. R11 was a nice man but would at times get anxious if he had nothing to do. R11 always seemed to need something to do but once you found something to occupy him, he was fine. NA-H stated R11 was very nice and liked to read the paper in the dining area and people watch. R11 enjoyed visiting with others and staff frequently sat down with him to visit and he would laugh and joke with them. Never resistive or combative with cares or others. R11's progress notes, dated 1/28/25 to 2/24/25, were reviewed. A progress note dated 2/18/25, identified R11's mood was pleasant with no unwanted behaviors witnessed and R11 slept through the night. No behavioral incidents were recorded in the 28-day period reviewed. R11's medical record lacked evidence what symptoms or specific behaviors were being tracked or monitored to ensure the efficacy of the ordered quetiapine and gabapentin and support the use of the medications. During interview on 2/27/25, at 9:33 a.m. registered nurse (RN)-B stated R11 had dementia and experienced a lot of anxiety, but she never witnessed aggressive behaviors. The gabapentin was increased on 2/24/25, for R11's own comfort to see if they could make him feel better. R11 would wander and get very anxious and make comments that he did not know why he was here or what he should be doing. R11 seemed more comfortable now and less episodes of those behaviors happening. RN-B did not do rounds with the mental health provider NP-F and so was not sure what was discussed when NP-F increased R11's medication. R11's anxiety was not on the care plan, and it should have been. It would be important to list the type of behavior R11 exhibited and the interventions so staff could utilize them before medication to decrease R11's symptoms of loneliness and depression. During telephone interview on 2/27/25, at 12:54 p.m. the consultant pharmacist (CP)-E stated R11 received quetiapine at bedtime for dementia and that was not an appropriate diagnosis for the medication unless there was evidence the behaviors could harm self or others. There were usually targeted behaviors and non pharmalogical interventions in the care plan related to the use of antipsychotic medications and she had noticed R11's care plan did not address behaviors. CP-E had also noted NP-F had increased R11's gabapentin in January and there was no rationale for the increase in R11's medical record. CP-E reviewed all the progress notes for behaviors as well and could not find rationale for the medication increase documented. During interview on 2/27/25, at 2:12 p.m. the DON stated she would expect anxiety and related behaviors to have been documented on R11's plan of care. She knew R11 had a lot of anxiety, and she would have expected some behavioral incidents to have been documented in his progress notes to justify the initiation and two increased doses of gabapentin ordered and/or whether the medication was successful or not. Dementia alone was not enough of a reason to prescribe quetiapine or gabapentin, and the DON needed to speak with the provider regarding the issue. During telephone interview on 2/27/25, at 3:29 a.m. with R22's primary physician (DR)-A stated he was not sure who had first prescribed quetiapine for R11, however, he thought he had done the admission orders. The diagnoses just popped up on the chart and he picked the most appropriate diagnosis. DR-A was not aware of all the regulations and the issues had not been brought up to him when he conducted rounds at the facility. R11 was seen by a mental health provider NP-F and she would be more aware of all the regulations surrounding those type of medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/27/25, at 4:01 p.m. NP-F was called with a request for a return call; however, none was received. The facility policy Psychotropic Medications dated 8/20/24, identified the facility would have the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, behavioral interventions and psychopharmacological medications could be utilized to meet the needs of the individual resident. Primary providers would order psychotropic medication only for the treatment of specific medical and/or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by non-pharmacological approaches. The provider would document rationale and diagnosis for use and identify Target Behavior symptoms for the reason the medication was being utilized. PRN psychotropic medications ordered would be limited to 14 days. The prescribing practitioner would evaluate and document the medications necessity, benefits, and improvement (expressions, indications of distress). If the physician deemed it appropriate to extend beyond the 14-day limit, supporting rationale must be documented. The facility staff would monitor and document for the presence of target behaviors daily, charting by exception (i.e., charting only when the behaviors are present), noting any adverse effects, review usage of the medications with the physician and the IDT on a quarterly basis to determine the continued presence of target behaviors and/or presence of any adverse effects, implement non-pharmacological interventions for target behavior(s), document results, and add to care plan, and utilize PRN psychotropic medication, following provider order, if non-pharmacological intervention(s) are unsuccessful.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575 Based on observation, interview and document review, the facility failed to implement transmission-based precautions (TBP) for respiratory symptoms until confirmatory respiratory test results were obtained for 6 of 38 residents (R34, R31, R11,R22, R36, R32), failed to initiate droplet precautions for 1 of 6 residents (R31) known to test positive for influenza A, failed to implement strategies to mitigate the risk of an influenza outbreak, including initiating active surveillance of residents for signs and symptoms of influenza A, isolation of residents presenting with symptoms of influenza A, and post signage at the facility entrances to notify visitors of active illness in the facility. This resulted in a system wide failure in infection control procedures to prevent the spread of illness within the facility when 8 of 38 residents (R31, R11 , R36, R32, R38, R7, R35, R3) contracted influenza A. This resulted in an immediate jeopardy (IJ) which placed all 38 residents at a high likelihood for serious illness and/or death by contracting a communicable disease, including but not limited to influenza A. In addition, the facility failed to track and trend all resident actual/potential infection on the monthly tracking form to effectively identify symptoms and reduce the spread of infection with a potential to affect all 38 residents residing in the facility. The IJ began on 2/13/25, when R34 exhibited symptoms of respiratory illness, was not isolated or placed on TBP when symptoms were exhibited, and subsequently tested positive for influenza A on 2/14/25, and failed to implement interventions to reduce the spread of influenza A which resulted in eight other residents contracting influenza A. The director of nursing (DON) was notified of the IJ on 2/24/25, at 9:27 p.m. The IJ was removed on 2/26/24, at 10:26 a.m. when the facility implemented actions to reduce/prevent the spread of illness. However, noncompliance remained at the lower scope and severity, F widespread, which indicated no actual harm with potential for more than minimal harm that was not IJ. Findings include: INFLUENZA A OUTBREAK: The Interim Guidance for Influenza Outbreak Management in Long-Term Care and Post-Acute Care Facilities from the Centers of Disease Control (CDC) dated 9/17/24, identified influenza can be introduced into a long-term care facility by newly admitted residents, healthcare personnel, and visitors. Spread of influenza can occur between and among residents, healthcare personnel and visitors. Residents of long-term care facilities can experience severe and fatal illness during influenza outbreaks. If one laboratory-confirmed influenza positive case was identified along with other cases of acute respiratory illness in a unit of a long-term care facility, an influenza outbreak might be occurring. Active surveillance for additional cases should be implemented as soon as possible once one case of laboratory-confirmed influenza is identified in a facility. When 2 cases of laboratory-confirmed influenza were identified within 72 hours of each other in residents on the same unit, outbreak control measures should be implemented as soon as possible. Droplet precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Droplet Precautions should be implemented for residents with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a resident is in a healthcare facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The CDC guidance for Flu and People [AGE] years and Older dated 9/5/24, identified people [AGE] years and older are at higher risk of developing serious flu complications compared with young, healthy adults. This increased risk is due in part to changes in immune defenses with increasing age. While flu seasons vary in severity, during most seasons, people [AGE] years and older bear the greatest burden of severe flu disease. In recent years, for example, it ' s estimated that between 70 percent and 85 percent of seasonal flu-related deaths have occurred in people [AGE] years and older, and between 50 percent and 70 percent of seasonal flu-related hospitalization s have occurred among people in this age group. On 2/24/25, at 11:30 a.m. surveyors entered the facility to conduct an annual recertification survey. No signs were posted to alert visitors an influenza outbreak was occurring in the facility. During the entrance conference 2/24/25, at 12:26 p.m. with the DON, the DON failed to identify there were any residents ill with respiratory illness or the facility may be experiencing an influenza outbreak. R34: R34's significant change Minimum Data Set (MDS) dated [DATE], identified R34 was [AGE] years of age and had moderately impaired cognition. R34 required maximum assistance with most activities of daily living (ADLs). R34 was vaccinated for influenza on 10/11/24. Diagnoses included Alzheimer's disease, acute kidney failure and encephalopathy. R34's progress notes identified on 2/12/25, R34 had developed a hoarse voice and dry cough and on 2/13/25, R31 had developed a low-grade temperature. A positive influenza test was identified on 2/14/25. Droplet precautions were put into place on 2/14/25. R34's medical record failed to identify transmission-based precautions were implemented when R34 first presented with respiratory symptoms to prevent the spread of influenza A to other residents and staff. R31: R31's quarterly MDS dated [DATE], identified R31 was [AGE] years of age and had intact cognition. R31 required partial assistance with dressing and was dependent with toileting and bathing. R31 was vaccinated for influenza on 10/10/24. Diagnoses included congestive heart failure, and diabetes. R31's progress note on 2/23/25, identified R31 complained of not feeling well with body aches and wheezes noted in both lung fields. R31 was sent to the emergency room to be evaluated and returned on 2/24/25, at 2:20 a.m. with a positive influenza A test result. R31's medical record failed to identify droplet precautions were implemented when R34 returned from the hospital positive for influenza A, to prevent the spread of influenza A to other residents and staff. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 2/24/25, at 3:20 p.m. prior to the surveyor entering the room for screening nursing assistant (NA)-A stated R31 was on enhanced barrier precautions because R31 had a catheter in place. Staff were required to wear gown and gloves when providing close contact care. The personal protective equipment (PPE) was not required to visit with resident if not in close contact with resident. The surveyor proceeded to enter the room to complete the screening process for the survey. On 2/24/25, at 4:46 p.m. trained medication aide (TMA)-A was observed removing the enhanced barrier precaution sign on R31's door and placing a droplet precaution sign on the door. During interview on 2/24/25, at 4:46 p.m. TMA-A stated R31 only had enhanced barrier precautions sign on his door, which directed staff to gown and glove when providing personal care and did not require staff to mask. TMA-A had just put a new droplet precaution sign on R31's door that directed all persons to gown, glove, and mask prior to entering the room. TMA-A stated all the staff working that day were aware R31 had tested positive for influenza A since his return from the emergency room at 2:30 a.m., as it was reported during shift report that morning. The precautions sign had just not been changed. (the droplet precautions were placed 13 1/2 hours later) When interviewed on 2/24/25, at 4:59 p.m. the infection preventionist registered nurse (RN)-A stated R31's precautions should have been changed from enhanced barrier precautions to droplet precautions as soon as he returned from the emergency department. R11: R11's admission MDS dated [DATE], identified R11 was [AGE] years of age and had severe cognitive impairment. R11 required moderate assistance with dressing, bathing, and toileting. R11 was vaccinated for influenza prior to his admission to the facility. Diagnoses included malignant neoplasm of the rectal sigmoid junction and thrombocytopenia. R11's progress note(s) identified on 2/24/25, R11 had required administration of acetaminophen 650 milligrams at 7:54 a.m. for a temperature of 101.4. On 2/24/25, at 1:13 p.m. a family member (FM)-A was observed sitting on R11's bed, in very close contact with R11, who was seated in his recliner in his room. FM-A stated R11 had a temperature that morning and had fallen getting out of bed as he was so weak. The facility had tested him for respiratory illness and were waiting on the results. FM-A was not wearing any PPE and there was no evidence transmission-based precautions were not implemented with close contact with R11. During observation on 2/24/25, at 1:20 p.m. two unidentified nursing assistants (NA) were seen entering R11's room to assist his roommate R14 to bed. R11 was seated in his recliner in the room, next to the fully open privacy curtain. The NAs drew the privacy curtain halfway across the room and assisted R14 to bed using a mechanical lift. The NAs re-opened the privacy curtain, used alcohol-based hand rub on their hands after completing the task and exited the room. Neither NA's put on personal protective equipment. There was no signage or PPE cart outside of R11's room to alert staff to the need for PPE when entering the room to prevent potential transmission to others. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 2/24/25, at 6:18 p.m. NA-C and NA-D were observed assisting R11 to the bathroom. NA-C, wearing mask and gloves, was kneeling in front of R11 who was seated on the toilet. NA-D was outside of the bathroom making the bed up. NA-D did not have gown or mask on. NA-D stated she remembered someone mentioning something about wearing a mask but had forgotten. NA-D exited the room to read the precaution sign posted on R11's room door. The sign indicated R11 was on droplet precautions, and everyone must wear a mask and clean hands on entering and leaving the room. If contact with secretions were likely staff were directed to use gown, gloves and eye cover as well. NA-D stated she now realized she needed to wear a gown and mask. NA-D put on a gown and surgical mask and brought NA-C an isolation gown to put on. R11's progress note on 2/24/25, at 6:31 p.m. identified R11 tested positive for influenza A and was placed on droplet precautions. Appropriate signage and a PPE cart were placed outside of his door. R22: R22's admission MDS dated [DATE], identified R22 was [AGE] years of age and had severe cognitive impairment. R22 required supervision with ADL's. R22 had not been vaccinated for influenza virus. Diagnoses included neurocognitive disorder with Lewy bodies, and heart disease. During observation on 2/24/25, between 1:00 p.m., to 5:30 p.m. R22 was lethargic, lying halfway on his bed with both feet on the floor. R22 did not wake to eat lunch. At 2:00 PM. TMA-A and another unidentified staff member were attempting to arouse R22 to drink water. Neither staff were wearing any PPE. There were no isolation precautions or PPE cart noted in the room. R22's progress note(s) identified the following: - 2/24/25, at 11:09 a.m. a respiratory panel was completed for cough, headache and body aches. - 2/24/25, at 2:02 p.m. identified R22 had been wandering throughout the shift, into other resident rooms and was difficult to redirect. - 2/24/25, at 7:20 p.m. identified R22 had not been feeling well that day and had complained of ear pain, neck pain and headache R22 had a temperature of 100.4 and oxygen saturation was 92%. A respiratory panel had been completed with results pending. R22 was sent to the emergency room for further evaluation. - 2/25/25, at 3:21 a.m. identified R22 had returned from the emergency room . R22's respiratory panel was negative, however, R22 continued to complain of neck pain, refused to eat his meals and remained in bed. R22's medical record failed to identify transmission-based precautions were implemented when R22 first presented with respiratory symptoms on 2/24/25, to prevent the spread of potential respiratory infections to other residents and staff. R36: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R36's admission MDS 12/11/24, identified R36 was [AGE] years of age and had intact cognition. R36 was independent with his ADLs. R36 had been vaccinated for the influenza prior to his admission to the facility. Diagnoses included chronic obstructive pulmonary disease, irritable bowel syndrome, and abnormal weight loss. During interview on 2/24/25, at 2:51 p.m. R36 stated he was not feeling well and had not eaten much in two weeks. R36 reported he had fallen that morning because he was so weak. There were no isolation precautions, signage or PPE cart noted in the room. On 2/24/25, at 3:28 p.m. R36 was observed dressed in coat, hat and gloves, ambulating down the hallway. R36 stated he was going outside to smoke a cigarette. R36 stopped at the nurse's station and visited with the nurse for several minutes, before obtaining a cigarette and going outside to smoke. R36's progress note dated 2/24/25, at 7:42 p.m., identified R36 had tested positive for influenza A and was placed on droplet precautions. R32: R32's quarterly MDS dated [DATE], identified R32 was [AGE] years of age and had intact cognition. R32 was independent with ADL's. R32 had refused the influenza vaccine. Diagnosis included chronic obstructive pulmonary disease. R32's progress note(s) identified the following: - 2/23/25, R32 complained of chest congestion and had a temperature of 101.2. - 2/24/25, R32 was positive for influenza A and placed on droplet precautions. R32's medical record failed to identify transmission-based precautions were implemented when R34 first presented with respiratory symptoms on 2/23/25, to prevent the spread of influenza A to other residents and staff. During observations on 2/24/25, there continued to be no signs posted on the facility entrances to inform visitors and staff of influenza in the building. When interviewed on 2/24/25, at 6:10 p.m. RN-A stated when residents exhibit a cough or elevated temperature the facility encouraged the resident to stay in their room. If the resident needed to come out of their room, they were encouraged to wear a surgical mask and did not implement transmission-based precautions. The facility did not implement droplet precautions unless the resident had a positive test result for influenza. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During interview on 2/24/25, at 6:29 p.m. the director of nursing (DON) stated R34 was the facility's first case of confirmed influenza. R34 tested positive for influenza A on 2/13/25 and was placed on droplet precautions on 2/14/25 and not when R34 first developed symptoms. When residents did not feel well, the facility tried to limit exposure to the ill resident until they had confirmed test results. R31 tested positive for influenza A during his visit to the emergency room and should have been isolated and placed on precautions on his return. The DON indicated she thought six other residents had some symptoms of respiratory illness and had been tested . The residents were not on transmission- based precautions but were asked to stay in their rooms as much as they could. Staff and visitors were not required to wear PPE to enter the resident rooms and some of the symptomatic residents did share their room with a roommate. The DON stated residents who exhibited any symptoms of respiratory illness should be placed in transmission based-precautions, a respiratory test completed and then placed in droplet precautions with a confirmed test however, the documentation did not reflect that. When interviewed on 2/24/25, at 7:33 p.m. the DON stated the facility was now implementing droplet precautions with all residents who exhibited symptoms of acute illness and not waiting for lab results before implementing the precautions. However, the facility was not doing any active surveillance for monitoring for influenza A and only obtained vital signs including temperatures weekly unless they report symptoms of illness or the facility staff notice something was off. Further, the facility had not done anything different with roommates of residents with influenza A such as isolating them or offering room changes. The DON felt when they did that during the COVID pandemic and felt it did not work and spread the illness further. During an interview on 2/26/25 at 3:41 p.m., RN-A stated she was responsible for the facility Infection Prevention and Control Program. RN-A started her role at the facility in November 2024 and worked as the facility's wound nurse as well. Staff would document any signs/symptoms of possible infections in the resident electronic medical record (EMR) and staff had the ability to initiate transmission-based precautions but had not done so until RN-A arrived to work on 2/24/25. Any resident with any sign or symptoms of infection should have been documented on the surveillance log to prevent the spread of illness. Further, the facility had not started active surveillance of residents to identify symptoms early. The facility identified via email R38 ,R7, R35 and R3 had subsequently positive influenza A tests: R38's admission MDS dated [DATE], identified R38 was [AGE] years old and had diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis and hemiplegia (weakness of one side of the body) following a stroke and hypertension. R7's quarterly MDS dated [DATE], identified R7 was [AGE] years old and had diagnoses that included chronic obstructive pulmonary disease (COPD) (a lung condition caused by damage to the airways and alveoli), asthma and hypertension. R35's quarterly MDS dated [DATE], identified R7 was [AGE] years old and diagnoses that included hypertension and type 2 diabetes. R3's quarterly MDS dated [DATE], identified R3 was [AGE] years old and had diagnoses that included atrial fibrillation (irregular heartbeat), heart failure and chronic kidney disease. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility Influenza A and B or Lung MDRO policy dated 9/11/17, identified in addition to standard precautions, staff were to implement droplet precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets that can be generated by the individual coughing, sneezing, talking or by the performance of procedures such as suctioning. If the resident's cognition and physical ability was such that they were consistently able to cover their cough and place the tissue in a trash bag, they could come out of their room and have company without wearing a mask. The resident must be able to follow instructions and do proper hand hygiene. Place resident in a private room. if private room was not available and cohorting was not achievable, staff were directed to use curtain in room and maintain at least three feet of space between infected resident and other residents or visitors. In addition to standard precautions, staff were to wear a mask when working within three feet of the resident. The facility Resident Influenza policy dated 5/1/24, identified influenza was a highly contagious infection of the respiratory tract caused by a virus and transmitted by air-borne droplet infections. Typical influenza illness was characterized by abrupt onset of fever/chills, myalgia, sore throat and non-productive cough. Staff were instructed to report to the charge nurse or infection prevention any suspicion of residents exhibiting influenza symptoms. Employees with a fever of 100.4 or higher should not come to work. use proper handwashing techniques, use appropriate PPE when caring for residents with symptoms of influenza. any resident with influenza symptoms or fever over 100.4 must eat in their room. Keep resident away from activities or therapies if contagious and discourage visitors. All cases of influenza would be entered on the facility infection control logs. The IJ that began on 2/13/25, was removed on 2/26/25, at 10:26 a.m., when it could be verified through observation, interview and document review the facility implemented droplet precautions for all residents that tested positive for influenza A, implemented a system for ongoing active surveillance of residents for symptoms of influenza A, implemented transmission -based precautions for all symptomatic residents until confirmatory test resulted and the facility reviewed and revised their influenza policy to reflect current CDC guidelines. 40943 ONGOING INFECTION CONTROL SURVEILLANCE: The faciltiy provided an Infection Surveillance Report for each month that included resident name, case details, symptoms, lab results, treatment details and outcome. The facility Infection Surveillance Report dated January 2025, was reviewed and failed to include R13's influenza A exposure and symptoms. R13 R13's annual Minimum Data Set (MDS) dated [DATE], identified R13 had a severe cognitive impairment and diagnoses that included congestive heart failure (CHF), hypertension and type 2 diabetes. R13's nursing progress note dated 1/6/25, identified R13 was exposed to influenza A from roommate. R13 was also experiencing respiratory symptoms so R13 was swabbed for a respiratory panel which has been sent to the lab. Results pending. (continued on next page)

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 02/27/2025
NAME OF PROVIDER OR SUPPLIER: Littlefork Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 912 Main Street Littlefork, MN 56653	

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility Infection Surveillance Report dated February 2025, failed to include R34's respiratory signs and influenza A positive status, R34 R34's significant change MDS dated [DATE], identified R34 had a severe cognitive impairment and diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm), hypertension and dementia. R34's nursing progress notes identified: - 2/12/25 at 4:29 p.m., R34 from a nap this afternoon with a hoarse voice and dry cough. No fever noted or any other symptoms at this time. - 2/13/25 at 2:13 p.m., R24 continued to have a hoarse voice today and dry cough. She also had a low grade temp this morning. Resp Panel swab completed at 4:00 p.m - 2/13/25 at 2:14 p.m., R18 was sleepy today. Was running a low grade temp this morning. R34 received scheduled Tylenol. She was complaining of pain in her right shoulder and right hip. Pain meds were effective. R34 has not eaten well today but has been drinking fluids when given to her. R34 was propelling herself around in her wheelchair more. PT works with R34 daily. - 2/13/25 at 8:33 p.m., R34 wanted to go to bed soon after supper, she appeared tired, not as talkative as usual when asked she denied any pain, no coughing noted this shift, awaiting results of resp panel. Currently R34 asleep in bed respirations easy and regular at 18. R34 was able to get place to place by wheeling wheelchair and appeared to tolerate well. - 2/14/25 at 6:51 a.m., R34 tested positive for influenza A. Isolation precautions set up on R34's door. R34 was experiencing a low grade temp, cough, and hoarse voice. A skilled nurse is monitoring signs and symptoms. Plan of care ongoing. During an interview on 2/26/25 at 3:41 p.m., RN-A stated every day RN-A was scheduled to work, RN-A read through either the 24 hour or 72 hour report. For example, if RN-A did not work the weekend, RN-A would review the 72 hour report on Monday mornings. When RN-A was not working, there was no designated staff member to complete resident illness surveillance. Any resident with any sign or symptoms of infection should have been documented on the surveillance log to prevent the spread of illness. During an interview on 2/27/25 at 4:18 p.m., the DON stated all signs/symptoms of illness were expected to be documented and entered on the surveillance log to prevent the potential spread of illness. The facility policy Infection Surveillance revised 2/25/25, identified the facility would conduct ongoing surveillance for Healthcare-Associated Infections (Thais) and epidemiologically significant infections that have substantial impact on potential resident outcome.

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 02/27/2025
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42075 Based on interview and document review the facility failed to offer pneumococcal vaccination according to Centers for Disease Control (CDC) guidelines for 1 of 5 residents (R36) reviewed for vaccinations. Findings include: R36's admission Minimum Data Set (MDS) dated [DATE], identified R36 was admitted to the facility on [DATE], was [AGE] years old, at had diagnoses including chronic lung disease, used tobacco, and had mild cognitive impairment. The assessment identified R36 was not up to date with pneumococcal vaccination and the vaccination was not offered on admission. The undated facility immunization report identified R36 had received the PPSV23 on 11/18/19, and PCV13 on 10/31/18. R36's electronic health record did not include evidence R36 or R36's representative were offered/received education regarding pneumococcal vaccine booster(s) such as the PCV15 or PCV20 in conjunction with their provider. On 2/27/25 at 2:57 p.m., registered nurse (RN)-A stated vaccines were discussed and offered upon admission. The pneumococcal vaccine was offered according to the CDC guidance and provided individually. RN-A stated she used the PneumoRecs VaxAdvisor recommended by the CDC to help determine when pneumococcal vaccines were needed. RN-A stated R36 could have had a pneumococcal vaccine on 11/18/24. RN-A stated she should have offered the vaccine to R36 and/or R36's representative however, had not offered the vaccine. On 2/27/25 at 3:17 p.m., the director of nursing (DON) stated staff were to use the PneumoRecs vaccination website recommended by the CDC to help determine if a resident is up-to-date with their pneumococcal vaccine. The DON stated she was not aware of when residents were offered the vaccine. The Resident Immunizations policy revised 1/21/25, identified all residents would be offered vaccinations based on the CDC recommendations and physician orders. The policy further identified the facility would utilize the Adult Immunizaton Schedule, prepared by the CDC, to ensure residents were offered and encouraged to accept the appropriate vaccinations, and the determination to vaccinate or not would be documented in the residents electronic medical record.