DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 19, 2023

Administrator
St Ottos Care Center
920 Southeast 4th Street
Little Falls, MN 56345

RE: CCN: 245257
Cycle Start Date: November 10, 2022

Dear Administrator:

On December 30, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Electronically delivered
November 22, 2022

Administrator
St Ottos Care Center
920 Southeast 4th Street
Little Falls, MN 56345

RE: CCN: 245257
Cycle Start Date: November 10, 2022

Dear Administrator:

On November 10, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 10, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 10, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245257	A. BUILDING _____ B. WING _____	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/7/22-11/10/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/7/22-11/10/22, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity.	F 604		12/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/01/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 604	Continued From page 1 The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assess for restraints for 1 of 1 residents (R44) reviewed for use of a seatbelt. Findings include: R44's quarterly Minimum Data Set (MDS) dated	F 604	F604 Right to be Free from Physical Restraints F604 CFR(s): 483.10(e)(1), 483.12(a)(2) St. Otto's Care Center intends to develop and implement policies and procedures to protect the Right to be Free from Physical Restraints. This will be completed by:	

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F 604	Continued From page 2 10/21/22, identified R44 was not able to understand others or communicate his needs. R44's skills for daily decision making were severely impaired. R44's MDS indicated no restraints. R44's face sheet dated 11/9/22, indicated R44's diagnoses include epilepsy (seizure disorder), cerebral atrophy (loss of brain cells) and profound intellectual disabilities. R44's medical record lacked a physical assessment, progress notes indicating use and physician orders for use of a restraint. During an observation on 11/7/22, at 3:45 p.m. R44 was seated in his wheelchair in the facility day room. A seat belt, secured to the back of the wheelchair, was latched closed at R44's waist. R44 was not restless and his eyes were closed. No staff were in the day room. On 11/9/22, at 7:43 a.m. nursing assistant (NA)-D stated she frequently worked with R44 and was familiar with his care needs. NA-D stated she sometimes secured the seatbelt for R44, depending on his mood. NA-D was not aware if there was an order for R44's seatbelt and confirmed it was not on the care plan. NA-D acknowledged use of the seatbelt was considered a restraint, but felt he was "grandfathered in" because he used it at his previous facility. NA-D stated she used the seatbelt when R44 was upset, after getting direction from the nurse. On 11/9/22, at 7:47 a.m. licensed practical nurse (LPN)-C indicated use of a restraint required an assessment and orders. LPN-C confirmed R44 did not have physician orders or an assessment	F 604	Friday, December 9, 2022 The facility failed to assess for restraints for 1 of 1 resident (R44) reviewed for using a seatbelt. A.Correction to residents: R44's resident's seatbelt and foot straps were removed from their wheelchair on 11/11/22. B.Process put in place to prevent from reoccurring a.All residents were audited for the use of physical restraints. b.The Restraint Policy was reviewed on 11/12/22, and education was provided to all nursing staff at the nursing meeting on 11/17/22. Education will continue until all nursing staff has been educated on the restraint policy and procedure. C.Auditing Plan a.Wheelchairs and devices will be audited by DON or designee on new admissions to ensure no restraints are in place. If necessary, Restraint Policy will be followed as appropriate. b.The DON or designee will complete weekly audits based on the MDS schedule for the completion of an up-to-date safety risk and elopement assessment. c.Audit results will be reported at QAPI monthly.	

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F 604	Continued From page 3 to use the seatbelt. LPN-C stated she had not given instruction for use of the seatbelt and had not seen it in use. On 11/9/22, at 9:55 a.m. registered nurse (RN)-A confirmed use of restraints required an assessment, care planning, and orders. RN-A stated she was not aware of residents in the facility currently assessed for or approved for use of restraints. On 11/9/22, at 10:07 a.m. director of nursing (DON) stated there were no restraints in use in the facility. DON was aware R44 had a seatbelt on his wheelchair, it was on the wheelchair when R44 admitted. DON indicated she did not feel R44's seatbelt was warranted at this time as his seizures are well controlled. Facility policy Restraint Use reviewed date 5/2019, indicated the need for restraint use is assessed on admission, at regularly scheduled interdisciplinary care plan conference reviews and as needed. A physician order is required prior to applying any type of restraint. Documentation with restraint use include pre-restraining assessment, fall risk assessment, MD order, family consent and quarterly review/reduction and daily documentation of every two hours release.	F 604		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		12/9/22

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F 684	Continued From page 4 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to properly assess for self-administration of medications. This had the potential to affect 1 of 1 residents (R47) reviewed for self-administration of medications. Findings include: R47's quarterly Minimum Data Set (MDS) dated 10/14/22, indicated R47 was sometimes able to understand others and was sometimes able to make himself understood. R47's cognition was severely impaired. R47's cognition was unchanged from his baseline. R47's face sheet dated 11/10/22, indicated R47's diagnoses included chronic obstructive pulmonary disease (COPD- disease causing breathlessness and cough), traumatic brain injury and dementia. R47's signed physician's orders dated 9/1/22-9/30/22, indicated R47 had orders for ipratropium-albuterol 0.5mg-3mg (medication to treat COPD) inhaled by nebulizer every two hours as needed. R47's physician's orders did not include orders to self-administer medications, including nebulizers. R47's care plan lacked instructions for self-administration of medications. R47's medical record failed to include an assessment for self-administration of	F 684	F684 CFR(s): 483.25 Quality of Care St. Otto's Care Center intends to develop and implement policies and procedures for the self-administration of medications. This will be completed by: Friday, December 9, 2022 The facility failed to assess for self-administration of medications properly for 1 of 1 resident (R47). A.Correction to residents a. R47's self-administration assessment, MD order, and care plan were updated on 11/11/22. B.Process put in place to prevent from reoccurring a. All residents using nebulizers were audited for compliance with a self-administration assessment, MD orders were obtained, and care plans were revised. b. Policy and Procedure on Self-Administration of Medications were reviewed on 11/16/22. Education on the Policy and Procedure of Self-Administration of Medications was provided to nursing staff on 11/17/22. Education will continue until all nursing staff has been educated on the Self-	

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F 684	Continued From page 5 medications. On 11/8/22, at 12:50 p.m. licensed practical nurse (LPN)-B was observed setting up an unknown medication in R47's nebulizer, placed the face mask on R47, turned on the machine and left the room. On 11/8/22, 12:56 p.m. LPN-B returned to R47's room. LPN-B made no adjustments to the nebulizer machine or mask and left the room and area of R47's room. On 11/8/22, at 1:04 p.m. LPN-B returned to R47's room. LPN-B turned off the nebulizer machine and removed the face mask. On 11/9/22, at 7:16 a.m. LPN-B set up an unknown medication in R47's nebulizer, placed the face mask on R47's face, turned the machine on and left the room. On 11/9/22, at 7:26 a.m. LPN-B returned to R47's room, turned off the nebulizer machine and removed the face mask. On 11/9/22, at 12:14 p.m. LPN-B confirmed the medication administered via nebulizer was ipratropium-albuterol. LPN-B stated for a resident to self-administer medications, including nebulizers, an assessment was completed. LPN-B stated, for R47, she was able to set up the medication, place the mask, turn on the machine and walk away if she continued to check on him. If LPN-B noted R47 having difficulty with the nebulizer, LPN-B would place her medication cart by R47's room while the nebulizer was running to keep a closer eye on him while continuing to pass medications to other residents. LPN-B confirmed	F 684	Administration of Medications policy and procedure. C.Auditing Plan a. All resident orders will be audited by the DON or designee weekly x 60 days for new nebulizer order for the completion of an up-to-date self-administration assessment. b. The DON or designee will complete weekly audits based on the MDS schedule for the completion of an up-to-date self-administration assessment. c. Audit results will be brought to QAPI monthly.	

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F 684	Continued From page 6 R47 was not previously assessed for self-administration of medications and did not have order for self-administration of medications, including nebulizers. On 11/10/22, at 9:33 a.m. director of nursing (DON) confirmed self-administration of a nebulized medication occurred when the medication was set up, the mask placed, the machine turned on and staff left the immediate area of the resident. She expected staff to stay within eyesight of any resident receiving a nebulizer treatment unless they have been assessed and determined safe to self-administer medications. DON stated she expected a signed physician's order for self-administration, specific to the medication, as well as instructions in resident's care plan would be found in the resident's record. DON confirmed R47's medical record did not include an assessment for self-administration of medications and R47's physician's orders did not include orders for self-administration of medications. Facility policy, Self-Administration of Medications by Residents with revision date 7/28/14, directed the interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		12/9/22

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F 688	Continued From page 7 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure passive range of motion (PROM) was performed for 1 of 4 residents (R30) reviewed for positioning and mobility. This failure had the potential to affect any resident who needed assistance implementing restorative care interventions. Findings include: R30's face sheet indicated the resident was admitted to the facility on 12/30/21 with a diagnosis of a stroke on the left side. Review of a document provided by the facility titled "Restorative Nursing Program Therapy Recommendation," dated 01/25/22, indicated R30 was to receive PROM to the left upper extremity in all three planes. On the resident's right side, R30 was to use three-pound bar bells, upper extremity curls, and diagonal supination/pronation five to seven times per week.	F 688	F688 Increase/Prevent Decrease in ROM/Mobility F688 CFR(s): 483.25(c)(1)-(3) St. Otto's Care Center intends to develop and implement policies and procedures to address and offer a range of motion exercises to residents listed in the restorative nursing program as described in the resident□s plan of care based on therapy recommendations. This will be completed by: Friday, December 9, 2022 The facility failed to ensure a passive range of motion (PROM) was performed for 1 of 4 residents (R30). A.Correction to residents a. R30's Program was reviewed and updated on 11/29/2022. B. Process put in place to prevent from reoccurring a. All resident restorative programs will be	

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F 688	Continued From page 8 R30's quarterly Minimum Data Set (MDS) indicated the resident had intact cognition. The assessment indicated that R30 required extensive assistance of one staff member for bed mobility and transfers and was impaired on one side of his body, both upper and lower extremities. R30's care plan indicated alteration in mobility due to a past stroke with left sided hemiplegia (paralysis). The care plan intervention was to provide left side PROM to upper extremities for all planes of motion. The resident's right side was to use a three-pound bar bell, curls, diagonal, supination, and pronation. The range of motion was to happen 12 to 15 times per month. This care plan intervention contradicted the directions for PROM from skilled therapy. During an interview on 11/09/22, at 10:10 a.m. Certified Nursing Assistant (CNA)-A stated she did not provide restorative services to R30. During an interview on 11/09/22, at 10:15 a.m. CNA-B stated he did not provide restorative services to R30 since the facility utilized a restorative CNA. During an interview on 11/09/22, at 10:17 a.m. CNA-C stated she was the restorative aide but got pulled to the floor frequently. During an interview on 10/09/22, at 11:24 a.m. the Director of Rehabilitation (DOR)-A stated R30 was referred to restorative nursing after he had completed skilled services. DOR-A stated the benefit of a resident placed on restorative nursing services was to maintain mobility and function.	F 688	reviewed and updated as appropriate. b. The restorative Nursing Policy was reviewed on 11/15/22 and reviewed during a nursing meeting on 11/17/22. Education will continue until all nursing staff has been educated on restorative nursing and range of motion exercises. C. Auditing Plan a. Residents will be audited weekly X 60 days on Restorative Programs for compliance. b. The results of audits will be brought to QAPI monthly.	

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	245257	A. BUILDING _____ B. WING _____	11/10/2022

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F 688	Continued From page 9 During an interview on 11/09/22, at 12:22 p.m. Licensed Practical Nurse (LPN)-A confirmed she supervised the restorative nursing program. LPN-A stated there had been no decline identified with R30. During an interview on 11/09/22, at 1:14 p.m. the Director of Nursing (DON)-B stated goals were set on a care plan in an attempt to achieve them for a resident and the facility does their best to accomplish the goals. During an interview on 11/10/22, at 8:59 a.m. DON-B stated her expectation for the restorative program would be to meet the restorative goals as directed by a resident's care plan. During a subsequent interview on 11/10/22, at 9:13 a.m. DON-B provided several documents which identified R30's sessions for the restorative program. The documents were titled "Nursing Rehab (Rehabilitation) Time Log." DON B stated for the month of 08/22 the resident received six restorative sessions. DON-B stated for the month of 09/22 the resident received 15 restorative sessions and for the month of 10/22 the resident received two restorative sessions. DON-B stated it was her expectation if the restorative aide was pulled to the floor, other CNAs were to complete the restorative sessions with the resident. DON-B stated the electronic medical record (EMR) prompted staff to identify the PROM ordered for the resident. During an interview on 11/10/22, at 9:50 a.m. R30 stated he completed his own PROM on his left arm. R30 stated no staff had worked with him with weights or on the left side which was affected by his stroke.	F 688		

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F 688	Continued From page 10 Review of a document provided by the facility titled "Restorative Nursing Policy," dated 06/15/22, indicated "...To incorporate interventions that promote a resident's ability to adapt and adjust to living safely and as independently as possible. It includes rehabilitation, management of behavioral symptoms, cognitive performance, and physical function..."	F 688		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to complete a performance review every 12 months for 2 of 3 nurse aides (NA-D & NA-E) reviewed for performance reviews. Findings include: NA-D's Employee Evaluation revealed her last performance review was completed on 08/30/19. NA-E's Employee Evaluation revealed his last performance review was completed on 06/01/18. On 11/10/21, at 9:00 a.m. the Director of Nursing (DON) verified last performance review was completed 8/30/19 for NA-D and 6/01/18 for	F 730	F 730 Nurse Aide Peform Review-12 hr/yr In-Service F730 CFR(s): 483.35(d)(7); 483.35(d)(7) Regular in-service education. St. Otto's Care Center intends to develop and implement policies and procedures to address Nursing Aide's Performance Reviews annually. This will be completed by: Friday, December 9, 2022 The facility failed to complete a performance review every 12 months for 2 of 3 nurse aides (NA-D & NA-E) reviewed for performance reviews. A. Correction to nursing aides	12/9/22

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F 730	Continued From page 11 NA-E. DON stated she was aware the performance reviews were late prior to the start of survey. Review of the undated "Employee Performance Evaluations" policy revealed it is the facility's policy to complete performance evaluations annually.	F 730	a. NA-D had their review completed on 11/29 & NA-E had their review completed on 12/1. B. Process put in place to prevent from reoccurring a. Policy and Procedure on Employee Performance Evaluations were reviewed on with the Director of Nursing for compliance standards on 11/22/2022. b. All nurse aide employee records were audited for compliance. Nursing performance reviews will be conducted weekly until compliance is met and processes are established. C.Auditing Plan a.The Administrator or designee will audit compliance weekly X 90 days and report results to QAPI monthly.	

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	245257	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/08/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted on11/08/2022, by the Minnesota Department Of Public Safety, State Fire Marshal Division. At the time of this survey, St. Otto's Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. St. Otto's Care Center is a three full story building with a partial fourth floor and partial basement. Floors one, two and three house the nursing home. The partial fourth floor is being used as office space and is separated by two hour construction. The partial basement is used for storage and mechanical functions and no nursing home residents go to this floor or the partial fourth floor. The 1968 building was constructed of a mix of Type II(222) and II(111) Construction. The facility has three wings that are three stories in height constructed of type II(111) construction connected to a center building that is four stories in height constructed of Type II(222) construction and is fully fire sprinkler protected. The 1999 addition is of Type II(111) construction and is also fully fire sprinkler protected. The facility was considered as an existing facility and was inspected as one building. The building has a fire alarm system with smoke detection by the smoke barrier doors and the	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 resident rooms are provided with single station battery powered smoke detectors. The building is connected via a grade level walkway to an adjacent apartments for senior assisted living. the connection between the nursing home and walkway is separated by a 2 hour rated building separation. The facility has a licensed capacity of 91 and had a census of 77 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are MET.	K 000		