*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
January 10, 2025

Administrator
St Otto's Care Center
920 Southeast 4th Street
Little Falls, MN  56345

RE: CCN: 245257
Cycle Start Date: November 8, 2024

Dear Administrator:

On December 12, 2024, the Minnesota Departments 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN  55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
November 19, 2024

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

RE: CCN: 245257
Cycle Start Date: November 8, 2024

Dear Administrator:

On November 8, 2024, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 8, 2025 (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 8, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

## INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN  55155
Office: 651-201-4384
Email: holly.zahler@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 _____ | C 11/08/2024 |

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

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| F 000 | INITIAL COMMENTS<br><br>On 11/4/24 through 11/8/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed with NO deficiencies cited:<br>H52571009C (MN00101853)<br>H52571010C (MN00104564)<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.<br><br>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 646 SS=D | MD/ID Significant Change Notification<br>CFR(s): 483.20(k)(4)<br><br>§483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to notify the county (designated | F 646 | F 646 D: The facility failed to notify the county (designated State Mental Health | 12/4/24 |

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

Electronically Signed | 11/27/2024

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 646 | Continued From page 1<br>State Mental Health Authority (SMHA)) for 1 of 1 resident (R76) with new onset mental illness.<br><br>Findings include:<br><br>R76's Census Record indicated admission on 4/17/24.<br><br>R76's quarterly Minimum Data Set (MDS) dated 8/26/24, identified R76 had intact cognition and required assistance with all activities of daily living (ADL)'s. R76's diagnoses included hypertension, urinary tract infection, diabetes mellitus, hyperlipidemia, depression, chronic obstructive pulmonary disease (COPD), hypothyroidism, polyarthritis, and major depressive disorder. MDS also indicated R76 hallucinated and had delusions. R76's prior MDS's had no identification of a psychotic disorder.<br><br>R76's psychiatric provider visit note dated 9/12/24, identified R76 was diagnosed with two new mental health diagnoses: Major neural cognitive deficits secondary to Alzheimer's with behavioral disturbance and Severe episode of recurrent major depressive disorder with psychotic features.<br><br>R76's care plan printed 11/6/24, identified resident received psychotropic medication related to depression, recent major life events/lifestyle changes. R2 had a history of hallucinations and delusional/paranoid thinking such as; hearing voices of specific staff coming from R76's television, saying bad things about her, thinks two staff are out to get her, worrying excessively at times about what people will think of her.<br><br>R76's Initial Pre-Admission Screening (PAS) | F 646 | Authority, SMHA) for one resident (R76) with a new onset mental illness.<br><br>" Resident R76: The PAS was completed on 11/8/2024 and documented in the resident's record, notifying the county SMHA. The resident's record was updated with the new diagnosis on 11/14/2024.<br>" Audit: All residents' charts were audited on 11/22/2024 to identify any other residents who may have experienced significant changes in condition that were not reported to the SMHA.<br>" Care Plan: R76's care plan was reviewed and updated to ensure all necessary services and supports are in place.<br>" Policy Review: The Pre-Admission Policy was reviewed and approved at QAPI on 11/22/2021 to ensure it included clear procedures for notifying the county SMHA of significant changes in residents' mental or physical conditions.<br>" Staff Training: On 11/22/2024, all appropriate staff were trained on the Pre-Admission Policy and the importance of timely notifications to the county SMHA.<br>" Audits: For two months, weekly audits will be conducted, focusing on significant changes in newly diagnosed mental health conditions and notable changes in the mental or physical condition of residents with mental illness or intellectual disabilities. Psychiatry records will be | |

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| F 646 | Continued From page 2<br>Results,dated 4/16/24, did not identify a diagnosis of mental illness, nor the need for a Level II PASARR to be completed.<br><br>During interview on 11/8/24 at 10:03 a.m., social worker (SW) stated she was not aware of R76's new mental health diagnoses. SW stated, had she been made aware, she would have contacted Senior Linkage Line (SLL) for guidance if a resident review was required. SW confirmed there were no new diagnoses entered into R76's health record. Therefore, she did not complete any follow up with the county. SW stated it was important for reassessment to occur to see what other services may be available for R76 to ensure the best possible care.<br><br>During interview on 11/8/24 at 10:14 a.m., Senior Linkage Line representative (SLLR) stated R76 would need to have a resident review done due to her new mental health symptoms. SLLR stated facility should contact the county to have a resident review completed. SLLR referred to their policy regarding when a resident review should be completed which indicated if "there is a change in the individual's situation that significantly changes the person's mental health symptoms or their need for mental health services." SLLR stated the intent of the resident review was to ensure the resident has been screened, they have access to services and to ensure where the resident was residing was appropriate.<br><br>The facility "Admission" policy dated 2/4/21, indicated the social worker is responsible for ensuring proper preadmission screening was completed by the referring agency to the Senior Linkage Line for PASARR Level I and II | F 646 | reviewed for any changes.<br>" Quality Assurance: The Quality Assurance Committee will review the results of the audits and monitoring activities to ensure ongoing compliance. The committee will follow up on any identified issues and take corrective actions as necessary.<br><br>Corrected date: 12-4-2024 | |

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| F 646 | Continued From page 3<br>screenings to provide appropriate services and rule out any mental health/MR/DD diagnosis that may require further follow up. The Social Worker will follow up on any MR/DD or mental health needs identified to ensure proper services remain in place and/or are documented in the chart. | F 646 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure provider orders were processed for 1 of 1 resident (R76) reviewed for change in mental status.<br><br>Findings include:<br><br>R76's quarterly Minimum Data Set (MDS) dated 8/26/24, identified R76 had intact cognition and required assistance with all activities of daily living (ADL)'s. R76's diagnoses included hypertension, urinary tract infection, diabetes mellitus, hyperlipidemia, depression, chronic obstructive pulmonary disease (COPD), hypothyroidism, polyarthritis, and major depressive disorder. PHQ9 score was 13. MDS also indicated R76 hallucinated and delusions. | F 684 | F 684:<br>" Incident Details: Resident R76's psychiatric provider dictation was reviewed, and<br>the appropriate diagnosis was added/updated in the resident's chart on 11/14/24.<br>Although the medication order was processed and implemented on 10/15/24, the new<br>diagnosis was not entered into the resident's chart until 11/14/24.<br><br>"Corrective Actions:<br>- The Director of Nursing (DON) or designee will audit all residents' charts,<br>reviewing 10 residents per week for 8 weeks or until compliance is achieved. | 11/27/24 |

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| F 684 | Continued From page 4<br>R76's psychiatric provider visit note dated 9/12/24, indicated due to the symptoms reviewed in the HPI (history of present illness), current diagnose should include: major neural cognitive deficits secondary to Alzheimer's with behavioral disturbance, and severe episode of recurrent major depressive disorder with psychotic features.<br><br>R76's psychiatric provider visit note dated 10/15/24, stated brexipiprazole for agitation and restlessness. R76 had hallucinations and delusions impacting her mental and physical well-being. The benefits of the medication far out weight the risks. Brexipiprazole 0.25 milligrams (mg) oral tablet for major neural cognitive deficits secondary to Alzheimer's with behavioral disturbance as well as severe episode of recurrent major depressive disorder with psychotic features.<br><br>During record review, the following diagnoses were not listed in R76's medical record: major neural cognitive deficits secondary to Alzheimer's with behavioral disturbance as well as severe episode of recurrent major depressive disorder with psychotic features.<br><br>R76's physician orders included orders for Rexulti (antipsychotic) 0.25 milligram (mg) by mouth at bedtime for major depressive disorder for seven days initiated on 10/15/24 and increased to 0.5 mg at bedtime on 10/22/24.<br><br>During interview on 11/8/24 at 10:52 a.m., registered nurse (RN)-B stated the health unit coordinator (HUC) printed off new provider visit notes and the RN reviewed them for anything new or anything that might have been missed. | F 684 | This audit includes reviewing provider dictations to ensure all new orders and diagnoses are processed timely.<br>- The Physician Orders and Progress Notes policy was reviewed on 11/18/24. Staff were reeducated on the policy on 11/21/24, and this reeducation will continue until all staff have been trained.<br>- The DON or designee will present the audit results to the QAPI team for review.<br><br>Corrected Date: 11/27/2024 | |

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| F 684 | Continued From page 5<br>RN-B stated whatever nurse that was on duty was the one who was responsible for reviewing orders/visit notes and making any changes needed.<br><br>During interview on 11/8/24 at 11:57 a.m., director of nursing (DON) and assistant director of nursing (ADON) stated the HUC printed out provider visit notes/dictations when they were available, and the RN reviewed them for anything new or something that stood out. DON and ADON confirmed that neither diagnosis was processed. Neither was listed on R76's current diagnoses. DON and ADON stated it was important to ensure all diagnoses were listed so everyone knows how to care for the resident at the best of their ability for all of the residents conditions. Important to see the "big picture".<br><br>The facility Physician orders and Progress Notes policy, dated 11/15/21, indicated orders written by physician will be transcribed by nurse and inputted into EMAR (electronic medication administration record) by HUC and then verified for completeness by nurse. Completeness to include resident name, physician name, date, time of order, order compete with medication name, dosage/treatment and time, frequency, diagnosis for medication, legible to interpret, stop date if applicable and signature/credential of nurse. Physician progress notes will be printed off and placed in residents' chart when available. | F 684 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited | F 688 | | 11/27/24 |

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| F 688 | Continued From page 6<br>range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and document review, the facility failed to implement interventions to prevent further development of decreased range of motion for 2 of 3 residents (R5 and R10) reviewed for positioning and mobility.<br><br>Findings include:<br><br>R5's quarterly Minimum Data Set (MDS) dated 10/16/24, indicated R5 was admitted to the facility on 4/15/21 and had a moderate cognitive impairment and diagnoses of diabetes.<br><br>R5's physical therapy (PT) discharge summary dated 7/14/21 through 8/13/21, indicated lower extremity (LE) exercises, LE ROM, and LE bike to maintain current level of performance, and prevent decline were recommended.<br><br>R5's care plan dated 10/23/24, indicated pulley exercises/or upper extremity (UE) active range of motion program (AROM) to be completed 3-4 | F 688 | F 688: The facility did not implement interventions to prevent further development of decreased range of motion for 2 of 3 residents (R5 and R10) reviewed for positioning and mobility.<br>Actions Taken:<br>" Reviewed and ensured the appropriateness of Resident R5 and R10□s restorative program and care plan. Resident R10 was discharged on 11/12/2024.<br>" Reviewed and updated restorative programs for all residents on 11/26/2024 to ensure goals and results are achievable to maintain mobility and current status.<br><br>Policy and Staff Education:<br>" Reviewed and updated the Restorative Nursing Policy on 11/18/2024. | |

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| F 688 | Continued From page 7<br>times a week and twice a day (BID) and a LE AROM program to be completed 3-4 times a week BID.<br><br>The facility document titled Point of Care History dated 9/5/24 through 11/5/24, reviewed 60 days of AROM documentation and included staff documentation for the number of minutes, and frequency of completion of AROM programs each day. It indicated R5's AROM programs had only been completed BID on two of the sixty days reviewed, on the other days it was documented as being completed only once, not answered, or not preformed.<br><br>R5's medical record lacked any documentation as to why the AROM programs were not completed or the rational for them not being performed.<br><br>R10's quarterly MDS dated 9/11/24, indicated R10 was admitted on 6/23/23, cognitively intact, and diagnoses included: coronary artery disease (CAD) (hardening of the arteries of the heart), heart failure (HF) (heart does not pump appropriately), neurogenic bladder (bladder does not contract when stimulated by the brain, loss of control), dementia, cerebral vascular accident (CVA) (stroke), hemiplegia or hemiparesis (inability to move one side of the body), paraplegia (loss of ability to move body), and depression.<br><br>R10's PT discharge summary dated 6/26/23 through 7/25/23, indicated a restorative program of ROM to the right UE, and right LE were recommended to prevent contractures and increase patient comfort.<br><br>R10's care plan dated 10/2/24, indicated UE | F 688 | " Reeducated staff on 11/21/2024 regarding restorative programs, expectations, and documentation of refusals or reasons for non-completion. This reeducation will continue until all staff have been trained.<br>Monitoring and Compliance:<br>" The Director of Nursing (DON) or designee will conduct audits twice a week for one month, then weekly for another month, or until the completion of residents' restorative programs to prevent further development of decreased range of motion.<br>" Audit results will be reviewed by the QAPI team to ensure ongoing compliance.<br><br>Corrected Date: 11/27/2024. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245257 | A. BUILDING _____ B. WING _____ | C 11/08/2024 |

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

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| F 688 | Continued From page 8<br>AROM to be completed 3-4 times a week BID and a LE PROM program to be completed 3-4 times a week BID.<br><br>The facility document titled Point of Care History dated 9/5/24 through 11/5/24, reviewed 60 days of AROM and PROM documentation and included staff documentation for the number of minutes, and frequency of completion of these AROM/PROM programs each day. It indicated R10's AROM and PROM program's had been completed BID on two of the sixty days reviewed for PROM, and three of the sixty days reviewed for AROM. On the other days it was documented as being completed once, not answered, not preformed, or refused.<br><br>R10's medical record lacked any documentation as to why the AROM/PROM programs were not completed other than refused on some occasions.<br><br>On 11/7/24 at 1:27 p.m., nursing assistant (NA)-A stated the NA's completed the ROM programs or the restorative aide staff if they were available, and would document unknown if they did not get the resident up, or were unsure if it was completed or done by another staff member. If they knew it was not completed, they would chart no information or did not occur. NA-A stated they typically would not report it if not completed, if someone from restorative was working they would assume the other staff had completed it.<br><br>On 11/7/24 at 3:51 p.m., the lead restorative licensed practical nurse (LPN)-A, stated six rehab team members and NA's were responsible for completing and documenting ROM programs in the point of care section of matrix. LPN-A stated | F 688 | | |

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| F 688 | Continued From page 9<br>they expected the ROM programs to be offered as ordered 3-4 times a week and BID. LPN-A stated if they documented not preformed, or not offered they simply did not have time to do it or did not complete the ROM programs. LPN-A stated it was important to complete ROM programs to prevent contractures, and not lose their ability to move.<br><br>On 11/7/24 at 5:20 p.m., the director of nursing (DON) stated they expected ROM programs were completed 3-4 times a week and BID to prevent contractures and decreased abilities.<br><br>The Restorative Nursing Policy last reviewed 10/24, indicated restorative programs are expected to be completed to maintain the resident at their highest level of functioning. | F 688 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a | F 758 | | 11/27/24 |

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|---|---|
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| F 758 | Continued From page 10<br>specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to implement and monitor orthostatic blood pressures and obtain a baseline AIMS (abnormal involuntary movement scale) with the initiation of an antipsychotic medication for 1 of 3 residents (R76) reviewed for antipsychotic medications. | F 758 | F 758: The facility did not implement and monitor orthostatic blood pressures or obtain a baseline AIMS (Abnormal Involuntary Movement Scale) assessment when initiating antipsychotic medication for 1 of 3 residents (R76) reviewed for such medications. | |

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|---|---|---|---|
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| F 758 | Continued From page 11<br>Findings include:<br><br>R76's quarterly Minimum Data Set (MDS) dated 8/26/24, identified R76 had intact cognition and required assistance with all activities of daily living (ADL)'s. R76's diagnoses included hypertension, urinary tract infection, diabetes mellitus, hyperlipidemia, depression, chronic obstructive pulmonary disease (COPD), hypothyroidism, polyarthritis, and major depressive disorder. PHQ9 score was 13. MDS also indicated R76 hallucinated and delusions. MDS indicated R76 needed supervision or touching assistance with transfers and ambulation.<br><br>R76's physician orders included orders for Rexulti (antipsychotic) 0.25 milligram (mg) by mouth at bedtime for major depressive disorder for seven days that started on 10/15/24 and was then increased to 0.5 mg at bedtime on 10/22/24.<br><br>R76's medical record was reviewed and lacked any evidence orthostatic blood pressures and AIMS assessment were initiated and/or had been obtained for R76 with the initiation of an antipsychotic medication.<br><br>During observation on 11/4/24 at 1:14 p.m., R76 was in her room and observed to self transferring to her wheelchair with no staff present.<br><br>During interview on 11/5/24 at 10:32 a.m., consultant pharmacist (CP) stated any resident on an antipsychotic medication should have orthostatic blood pressures and a baseline AIMS assessment initiated upon start of an antipsychotic medication. Pharmacist stated orthostatic blood pressures and AIMS assessment were important to monitor for side | F 758 | " Resident R76: Orthostatic blood pressures were completed on 11/14/24, and an AIMS assessment was done on 11/8/24. Orders were placed to repeat these assessments every six months.<br>" Audit: On 11/26/24, all residents' charts were audited to ensure AIMS and orthostatic BP assessments are completed for anyone on antipsychotic medication.<br>" Policy Review: The Orthostatic Hypotension Policy and the Antipsychotic Drug Indication Criteria Policy were reviewed on 11/20/24.<br>" Staff Education: Staff were reeducated on 11/21/24, with ongoing education until all staff are trained on proper monitoring processes for antipsychotic medications.<br>" Monitoring: The Director of Nursing (DON) or designee will conduct weekly audits for 8 weeks, followed by monthly audits for 2 months, or until the facility is in compliance, to ensure proper monitoring for those on antipsychotic medications.<br><br>Corrected Date: 11/27/2024 | |

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|---|---|---|---|
| | 245257 | A. BUILDING _____ B. WING _____ | C 11/08/2024 |

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

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| F 758 | Continued From page 12 | F 758 | | |

effects as it helped evaluate the risks verses benefits of the medication and helped the facility see the big picture. CP also stated it was important to monitor side effects of antipsychotic medications due to postural hypotension (lowering of the blood pressure that can cause lightheadedness, dizziness, and blurred vision) being one of the major side effects and would put the resident at a higher risk for falls when taking these medications.

During interview on 11/7/24 at 12:14 p.m., registered nurse (RN)-A stated orthostatic blood pressures and a baseline AIMS assessment were completed when antipsychotic medications were started and then every 6 months. RN-A stated AIMS assessment were important to complete so you can have early detection of side effects of the antipsychotic medications that may be irreversible. RN-A stated it was important to monitor orthostatic blood pressures for side effects that could affect the resident's mobility. RN-A stated R76's Rexulti was started on 10/15/24 and confirmed neither orthostatic blood pressures or a baseline AIMS assessment had not been initiated and/or completed for R76. RN-A confirmed R76 had a history of orthostatic hypertension so orthostatic blood pressures should have been initiated for R76.

During interview on 11/8/24 at 11:57 a.m., director of nursing (DON) and assistant director of nursing (ADON) stated monitoring for antipsychotic medications consisted of orthostatic blood pressures and a baseline AIMS assessment. DON and ADON stated that both orthostatic blood pressures and a baseline AIMS assessment should have been initiated at the start of an antipsychotic medication to monitor for side

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| F 758 | Continued From page 13<br>effects of the antipsychotic medication. DON and ADON confirmed that there were no orders for orthostatic blood pressures in place and a baseline AIMS assessment were not obtained/completed for R76.<br><br>The facility Orthostatic Hypotension policy, dated 8/15/22, indicated elderly have a natural incidence of postural hypotension and the possibility of post prandial hypotension. Orthostatic hypotension (OH) can be a consequence of normal aging, disease, and/or drug effect. Recommendations: OH blood pressures taken for initiation of antipsychotic medications.<br><br>The facility Antipsychotic Drug Indication Criteria policy, dated 3/2024, indicated if a resident is admitted already using an antipsychotic or, if facility is considering starting an antipsychotic medication, then side effect monitoring procedure established BEFORE medication initiated. An AIMS should be completed every 6 months on resident's taking an antipsychotic medication. Monitor orthostatic blood pressures at baseline and every six months in conjunction with the AIMS. | F 758 | | |

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| | 245257 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/06/2024** |

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

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>An annual Life Safety Code survey was conducted on November 6, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Otto's Care Center was found not 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division | K 000 | | |

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

Electronically Signed | 11/27/2024

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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|---|---|---|---|
| | 245257 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/06/2024** |

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

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|---|---|---|---|---|
| K 000 | Continued From page 1<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>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.<br><br>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 | K 000 | | |

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| K 000 | Continued From page 2<br>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.<br><br>The building has a fire alarm system with smoke detection by the smoke barrier doors and the resident rooms are provided with single station battery powered smoke detectors.<br><br>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.<br>The facility has a capacity of 91 beds and had a census of 81 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 521 SS=F | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2 | K 521 | | 12/6/24 |

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| | 245257 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **11/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 521 | Continued From page 3<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 19.7.6, 4.6.12, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 11/06/2024, between 9:00 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide a current fire damper inspection report for an inspection that had occurred in the last 4 years. Last available report was dated 09/09/2020.<br><br>An interview with the Administrator verified this deficient finding at the time of discovery. | K 521 | (K521) SS=F Plan of Correction for HVAC Fire Damper Inspection Deficiency<br><br>Steps to Correct the Deficiency:<br>1.Immediate Action:<br>- Fire damper inspection to be completed by 12/6/2024.<br>2.Documentation:<br>- Maintain detailed inspection records, including the date, findings, and any corrective actions taken.<br>- Update the fire damper inspection log to reflect the most recent inspection date and findings done 12/6/2024<br>3.Ongoing Compliance:<br>- A digital calendar reminder set for 30 days before the annual inspection due date is completed for the CEO, Administrator, and Maintenance Director to receive.<br>- Perform quarterly internal audits to verify that all fire safety equipment, including fire doors, is maintained and inspected according to schedule, and will be reported at QAPI PRN.<br>4. Verification:<br>- The Administrator will review the inspection report and corrective actions to ensure all deficiencies are addressed.<br>- The inspection results and any corrective actions will be reported to the facility's safety committee for review and oversight.<br><br>Completion Date: All corrective actions will be completed by 12/6/2024 | |

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| K 761 SS=F | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 19.7.6, 4.6.12, 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1 and 5.2.4.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 11/06/2024 between 9:00 AM and 12:30 PM, it was revealed by a review of available documentation and observation that the annual fire door inspection was last completed on 10/5/2023.<br><br>An interview with the Administrator verified this deficient finding at the time of discovery. | K 761 | (K761) SS=F Plan of Correction for Fire Door Inspection Deficiency<br><br>Steps to Correct the Deficiency:<br>1.Immediate Action:<br>- Fire door inspection completed 11/25/2024.<br>2.Documentation:<br>- Maintain detailed inspection records, including the date, findings, and any corrective actions taken.<br>- Update the fire door inspection log to reflect the most recent inspection date and findings done 11/25/2024<br>3.Ongoing Compliance:<br>- A digital calendar reminder set for 30 days before the annual inspection due date is completed for the CEO, Administrator, and Maintenance Director to | 11/30/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245257 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **11/06/2024** |

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

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|---|---|---|---|---|
| K 761 | Continued From page 5 | K 761 | receive.<br>- Perform quarterly internal audits to verify that all fire safety equipment, including fire doors, is maintained and inspected according to schedule- and will be reported at QAPI annually<br>4.Verification:<br>- The Administrator will review the inspection report and corrective actions to ensure all deficiencies are addressed.<br>- The inspection results and any corrective actions will be reported to the facility's safety committee for review and oversight.<br><br>Completion Date: All corrective actions will be completed by 11/30/2024. | |