DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL	ID: CJD9	
					E SURVEY AGENCY	Facility ID: 00817	
1. MEDICARE/MEDICAID PROVIDER NO (L1) 245257	Э.	3. NAME AND ADI (L3) ST OTTOS C		ГҮ		4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification	
2.STATE VENDOR OR MEDICAID NO.		(L4) 920 SOUTHE	EAST 4TH STRE	ET		3. Termination 4. CHOW	
(L2) 835542800		(L5) LITTLE FAL	LLS, MN		(L6) 56345	5. Validation 6. Complaint 7. On-Site Visit 9. Other	
5. EFFECTIVE DATE CHANGE OF OWN	IERSHIP	7. PROVIDER/SUF	PPLIER CATEGOR	Y	<u>02</u> (L7)	8. Full Survey After Complaint	
(L9) 05/17/2008		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA		
6. DATE OF SURVEY 11/07/	· · · ·	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	06/30	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	00/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				
From (a):		X A. In Complian	nce With		And/Or Approved Waivers Of The	e Following Requirements:	
To (b) :		Program Rec Compliance			2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director	
		1. A	cceptable POC		4. 7-Day RN (Rural SNF)		
12.Total Facility Beds	93 (L18)				5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	93 (L17)		pliance with Progran and/or Applied Waiv			(L12)	
		Kequitements	and/of Applied warv	eis.	* Code: A * 15. FACILITY MEETS	(L12)	
14. LTC CERTIFIED BED BREAKDOWN	10 CNIE	ICE	IID			(L15)	
18 SNF 18/19 SNF 93	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L13)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AP	PPROVAL Date:	
Teresa Ament, Ur	nit Superviso	or	11/07/2016	(L19)	Kate JohnsTon, Pr	ogram Specialist 11/15/2016 (L20)	
	PART II - TO	BE COMPLETE	D BY HCFA RI	. /	OFFICE OR SINGLE STAT		
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH C	IVIL	21. 1. Statement of Financial Solvency (HCFA-2572)		
X 1. Facility is Eligible to Part	icipate	RIGH	ITS ACT:		 Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA-1513)	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION	BEGINNING	DATE	ENDING DATI	E	VOLUNTARY 00	0 INVOLUNTARY	
02/01/1983					01-Merger, Closure	05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS	X - 7		03-Risk of Involuntary Termination	OTHER	
20. Lie Line, olor, Dine.	A. Suspension				04-Other Reason for Withdrawal	07-Provider Status Change	
			(L44)			00-Active	
(L27)	B. Rescind Sus	pension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DAT	ГЕ	Posted 11/18/2016 Co.		
	(L32)	11/15/2016		(L33)		NV/A I	
	(LJ2)			(L33)	DETERMINATION APPRO	JVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245257 November 15, 2016

Mr. Brian Bernander, Administrator St. Otto's Care Center 920 Southeast Fourth Street Little Falls, MN 56345

Dear Mr. Bernander:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 11, 2016 the above facility is certified for or recommended for:

93 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 93 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

St Ottos Care Center November 15, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 15, 2016

Mr. Brian Bernander, Administrator St. Otto's Care Center 920 Southeast Fourth Street Little Falls, MN 56345

RE: Project Number S5257026

Dear Mr. Bernander:

On October 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 21, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 7, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 21, 2016, effective October 12, 2016 and therefore remedies outlined in our letter to you dated October 4, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

St Ottos Care Center November 15, 2016 Page 2

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISI	Т
IDENTIFICATION NUMBER	A. Building			
245257 _{Y1}	B. Wing	Y2	11/7/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OTTOS CARE CENTER		920 SOUTHEAST 4TH STREET		
		LITTLE FALLS, MN 56345		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	Μ	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	Correction Completed 10/12/2016	ID Prefix F0312 Reg. # LSC	a)(3) Correction a)(3) Completed 10/12/2016		483.65 C	Correction Completed 0/12/2016
ID Prefix Reg. #	F0465 483.70(h)	Correction	ID Prefix	Correction	ID Prefix Reg. #		Correction Completed
LSC		10/12/2016	LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	(Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	C	Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	C	Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	C	Correction
Reg. # LSC		Completed	Reg. # LSC	Completed	Reg. # LSC	C	Completed
REVIEWE STATE AG		REVIEWED BY (INITIALS) PK/KJ	date 11/15/2016	SIGNATURE OF SURVEYOR	9433	date 11/07	7/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/21/2016			ANY UNCORRECTED DEFICIENCIES ED DEFICIENCIES (CMS-2567) SEN ⁻				

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245257 Y1	B. Wing	Y2	10/27/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OTTOS CARE CENTER		920 SOUTHEAST 4TH STREET		
		LITTLE FALLS, MN 56345		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	м	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC	K0038	10/10/2016	LSC		LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC					LSC _	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC					LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
REVIEWE STATE AG		REVIEWED BY ^(INITIALS) TL/KJ	date 11/15/2016	SIGNATURE OF SURVEYOR	29433	date 10/27/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/22/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY	ID: CJD9 Facility ID: 00817		
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245257 2.STATE VENDOR OR MEDICAID NO. (L2) 835542800 	TAKI	3. NAME AND ADI (L3) ST OTTOS C (L4) 920 SOUTHE	DRESS OF FACILIT CARE CENTER CAST 4TH STRE	Υ	(L6) 56345	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW		
5. EFFECTIVE DATE CHANGE OF OWNER (L9) 05/17/2008	RSHIP	(L5) LITTLE FAL 7. PROVIDER/SUF 01 Hospital		7 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 09/21/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30		
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY A. In Compliar Program Red Compliance	nce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	e Following Requirements: 6. Scope of Services Limit 7. Medical Director		
12.Total Facility Beds 13.Total Certified Beds	93 (L18)93 (L17)	X B. Not in Com	cceptable POC pliance with Program and/or Applied Waive		4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B *) 8. Patient Room Size 9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 93 (1.27) (1.28)	19 SNF	ICF	IID (1.42)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38) 16. STATE SURVEY AGENCY REMARKS ((L39)	(L42)	(L43) ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY AF	PPROVAL Date:		
Annette Truebenbach	n, HFE NE	II	10/24/2016	(L19)	Kate JohnsTon, Pro	ogram Specialist 11/14/2016 (L20)		
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR SINGLE STAT			
19. DETERMINATION OF ELIGIBILITY	pate		PLIANCE WITH C	IVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 02/01/1983 (L24)	23. LTC AGREEMI BEGINNING (L41)		 LTC AGREEME ENDING DATE (L25) 		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety		
	27. ALTERNATIVI A. Suspension o B. Rescind Sus	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	Έ	Posted 11/15/2016 Co.			
	(L32)			(L33)	DETERMINATION APPRO	VAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered October 4, 2016

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

RE: Project Number S5257026

Dear Mr. Bernander:

On September 22, 2016, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>Teresa.Ament@state.mn.us</u> Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 1, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 1, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 December 22, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

Enclosure

cc: Licensing and Certification File

		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		OME	B NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X		E SURVEY PLETED
		245257	B. WING _			09/2	21/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ST OTTO	S CARE CENTER				0 SOUTHEAST 4TH STREET TTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0(000			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 nic submission of the POC will cion of compliance.					
F 282 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN	F 28	282			10/24/16
	must be provided b	led or arranged by the facility y qualified persons in .ch resident's written plan of					
	by: Based on observat review, the facility fi- hygiene as directed residents (R55) rev living (ADL). Findings include: R55's quarterly Min 8/30/16, identified of dementia and heart	NT is not met as evidenced ion, interview and document ailed to complete personal by the plan of care for 1 of 3 iewed for activities of daily imum Data Set (MDS) dated liagnoses that included tailure. The MDS further red extensive assistance with			F282-D It is our intent to provide services as directed by the care plan. Upon discussion with surveyors and observation of R55 s fingernails by s R55 s fingernails were cleaned on 9/22/2016. Education to team memb regarding the need to review and follor resident care plans was completed by 10/18/16. Current nail care policy requiring nails to be cleaned at a minimum weekly, or as needed was a reviewed with team members by 10/18/2016. DON/designee will asses	staff, bers ow y also	
	/ DIBECTOR'S OB PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

Electronically Signed

10/12/2016

PRINTED: 11/15/2016

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.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED
		245257	B. WING _)/21/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
от отто	S CARE CENTER			920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 282	Continued From pa	age 1	F 28	32		
	comb/brush hair, p glasses, apply deor underarms, and pro- R55's ADL short te identified under gro but resident washe During observation was seated in her of the television. S a dark substance u R55 was again obs the television, with visible underneath observed again on	on 9/20/16, at 9:22 a.m. R55 wheelchair in her room in front several of R55's fingernails had inderneath them. At 3:18 p.m. served in her room in front of the dark colored substance several fingernails. R55 was 9/21/16, at 9:48 a.m. in her colored substance visible		residents needing nail care ADL s provided by 10/18/ DON/designee will comple ensure the ADL s have be per the care plan for 4 wee then with monthly audits. action will be completed by	16. te audits to een provided eks, followed Corrective	
	nursing assistant (I R55 with personal stated staff provide but se can wash he the washcloth. NA under any resident them and provide r observed R55 in th table, and verified t beneath several fin this would be taker When interviewed	on 9/21/16, at 8:42 a.m. NA)-A stated NA-B assisted hygiene this morning. NA-A e the majority of cares for R55, er hands after staff hand her -A stated if debris was noted 's fingernails, he would soak hail care. At this time NA-A e dining room, sitting at the there was a dark substance igernails on both hands, and n care of. on 9/21/16, at 9:24 a.m. NA-C provided on bath days.				

		AND HUMAN SERVICES				FORM	11/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245257	B. WING			09/2	21/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OTTO	OS CARE CENTER				20 SOUTHEAST 4TH STREET ITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	provides range of n NA-B verified she c cares this morning, R55 to wash her ov cares were comple hands, but denied r beneath R55's nails "probably would ha returned at 11:50 a bath on Wednesda getting a bath later, provided. NA-B ve to eat with a brown fingernails. On 9/21/16, at 12:2 sitting in a wheelch hands soaking in a and licensed practic present in the room were noted on the t this time, LPN-A ve substance beneath hands prior to being care is provided on expectation that sta fingernails if they an Facility policy titled effective 3/1/10, ide of care is the respo planning, implement joint participation by	 Anotion (ROM) to residents. Iid assist R55 with personal and provided a washcloth for vn face and hands. After te, ROM was provided on her noticing any dark substance s, and if it was noted she ve cleaned them." NA-B .m., stating R55 receives a y evenings, so would be when nail care would be rified it would not be sanitary substance beneath the P.7 p.m. R55 was observed air in her room, with both sudsy water filled basin. NA-A cal nurse (LPN)-A were both h, and a nail file and clipper able in front of the basin. At rified R55 had a dark several fingernails on both g soaked. LPN-A stated nail bath days, but it is her aff are cleaning resident's 	F	282			
F 312 SS=D	()()	CARE PROVIDED FOR IDENTS	F:	312			10/24/16
	A resident who is u	nable to carry out activities of					

Facility ID: 00817

If continuation sheet Page 3 of 13

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY
		245257	B. WING		00/	21/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		21/2010
от отто	S CARE CENTER			920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
F 312	maintain good nutri and oral hygiene.	the necessary services to tion, grooming, and personal	F 31	2		
	by: Based on observat review, the facility f provided to 1 of 3 m activities of daily liv dependent on staff Findings include: R55's quarterly Min 8/30/16, identified of dementia and hear identified R55 requ personal hygiene. Interview for Menta tool used to determ severe cognitive im R55's plan of care of comb/brush hair, pi glasses, apply deod underarms, and pro-	imum Data Set (MDS) dated diagnoses that included t failure. The MDS further ired extensive assistance with It also identified the Brief I Status (BIMS, as screening nine cognition) R55 to have apairment. dated 6/7/16, directed staff to rovide oral cares, wash dorant, wash hands/face, wash bovide perineal care. rm care plan dated 9/7/16, poming, staff: "does everything		F312-D It is our intent to provide to residents in need of set Upon discussion with surveyor observation of R55 s fingernal R55 s fingernals were cleaned Education to team members reneed to review and follow reside plans was completed by 10/18 Current nail care policy requiring be cleaned at a minimum weel needed was also reviewed with members by 10/18/2016. DO will assess all residents for nai 10/18/16. DON/designee will caudits to ensure the ADL s had provided per the care plan for followed then with monthly auc Corrective action will be completed.	rvices. s and ils by staff, d. egarding the lent care /2016. ng nails to <ly, as<br="" or="">n team N/designee I care by omplete ve been 4 weeks, its.</ly,>	
	was seated in her wo of the television. Se a dark substance u	on 9/20/16, at 9:22 a.m. R55 wheelchair in her room in front everal of R55's fingernails had nderneath them. At 3:18 p.m. erved in her room in front of				

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		AND HUMAN SERVICES				FORM	: 11/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245257	B. WING			09/2	21/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST OTTO	OS CARE CENTER				20 SOUTHEAST 4TH STREET ITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	the television, with visible underneath observed again on room, with the dark underneath several When interviewed of nursing assistant (N R55 with personal h stated staff provide but se can wash he the washcloth. NA-, under any resident' them and provide n observed R55 in the table, and verified t beneath several fin this would be taken When interviewed of stated nail care is p When interviewed of stated she is a nurs provides range of n NA-B verified she of cares this morning, R55 to wash her ow were complete, RO but denied noticing R55's nails, and if it would have cleaned 11:50 a.m., stating Wednesday evenin later, when nail care verified it would not brown substance but	the dark colored substance several fingernails. R55 was 9/21/16, at 9:48 a.m. in her colored substance visible fingernails. on 9/21/16, at 8:42 a.m. NA)-A stated NA-B assisted hygiene this morning. NA-A the majority of cares for R55, er hands after staff hand her A stated if debris was noted s fingernails, he would soak hail care. At this time NA-A e dining room, sitting at the here was a dark substance gernails on both hands, and	F	312			

Facility ID: 00817

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		AND HUMAN SERVICES				FORM	11/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245257	B. WING	i		09/:	21/2016
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OTTO	S CARE CENTER				020 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312 F 441 SS=F	sitting in a wheelcha hands soaking in a and licensed practic present in the room were noted on the t this time, LPN-A ve substance beneath hands prior to being care is provided on expectation that sta fingernails if they ar Facility policy titled /Skills dated effectiv hygiene, resident se 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and o to help prevent the of disease and infer (a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re	air in her room, with both sudsy water filled basin. NA-A cal nurse (LPN)-A were both h, and a nail file and clipper able in front of the basin. At rified R55 had a dark several fingernails on both g soaked. LPN-A stated nail bath days, but it is her aff are cleaning resident's re noted to be dirty. Activities of Daily Living (ADL) ve 9/14/10, identified under elf-image is maintained. I CONTROL, PREVENT tablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective affections.		441			10/18/16

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245257	B. WING			09/2	21/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ST OTTO	OS CARE CENTER				20 SOUTHEAST 4TH STREET ITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	 isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each di hand washing is incorressional practice (c) Linens Personnel must han transport linens so infection. 	t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted e. hdle, store, process and as to prevent the spread of	F4	441	F441-F It is our intent to maintain		
	program to include collected infection of transmission to othe had the potential to resided in the facilit Findings include; A facility Infection/A dated June 2016, ic infections: 3 Clostri- infections (infection causes inflammatio can cause flu-like s unknown respirator infections (UTI). Th specific resident, sy	elop an infection control the trending and analysis of data to reduce the risk of er residents in the facility. This affect all 79 residents whom y. Antibiotic Tracking Record dentified the following dium Difficile (C-Diff) caused by bacteria which n of the large intestine and ymptoms), 8 cases of y infection and 6 urinary track e report identified each ymptoms, treatment, isolation ction acquired information. The			infection control program. DON/des reviewed current procedures and education to team members will be completed by 10/18/16. DON/desig will review the Infection/Antibiotic Tr Record weekly ensuring tracking da record is complete allowing for an a to be completed to identify potential and/or spreading of infection. Analy data and trends will continue weekly DON/designee followed by appropri interventions and team member ed based on data reviewed. Corrective action will be completed by 10/18/1	nee racking ata on analysis I cause /sis of y by iate ucation e	

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		AND HUMAN SERVICES				FORM	: 11/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245257	B. WING	i		09/	21/2016
NAME OF	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OTTO	OS CARE CENTER				920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	record did not ident resided in, the orga infection was resolu- the collected data to infectious disease w if education to staff A facility Infection/A dated July 2016, idd infections: 5 UTI's, of the outermost lay and the inner surface and 2 methicillin res (MRSA, a bacteria) and the inner surface and 2 methicillin res (MRSA, a bacteria) antibiotics). The rec the resident resided when the infection was analysis of the colle potentially infection the facility or if educ necessary. A facility Infection/A Dated August 2016 infections, 13 UTI's staphylococcus skin identify what room to organism identified resolved. There wa data to determine if was spreading in th was deemed necess A facility Infection/A Dated September 2 infections: 3 bronch and 1 conjunctivitis what room the reside	ify what room the resident nism identified and when the ved. There was no analysis of o determine if potentially was spreading in the facility or was deemed necessary. Antibiotic Tracking Record entified the following 2 conjunctivitis (inflammation yer of the white part of the eye ce of the eyelid), 2 pneumonia sistant staphylococcus aureus resistant to several cord did not identify what room d in, the organism identified, or was resolved. There was no ected data to determine if s disease was spreading in cation to staff was deemed antibiotic Tracking Record , identified the following , 1 conjunctivitis, and 1 n infection. The record did not the resident resided in, the and when the infection was s no analysis of the collected potentially infectious disease the facility or if education to staff	F	441			

		AND HUMAN SERVICES				FORM	11/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245257	B. WING			09/:	21/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ST OTTO	S CARE CENTER				20 SOUTHEAST 4TH STREET ITTLE FALLS, MN 56345	EET 45 N OF CORRECTION (X5) E ACTION SHOULD BE D TO THE APPROPRIATE DATE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION
F 441	There was no analy determine if potenti spreading in the fac deemed necessary. Review of a first qu for January-March 2 gastroenteritis (infla gastrointestinal trac vomiting and abdorn hand washing audit Review of the secon Report for April-Jun higher rate of respin particular lane and depending on their increase in UTI's ho an infection control precautions, providi hygiene. When interviewed of director of nursing (responsible for the collected by the fac reviewed it on a we was analyzed for tre incidents identified the identified organ beginning of Janual the medical director organisms from urin trends as there had the facility. In June to nursing assistant	vsis of the collected data to ally infectious disease was cility or if education to staff was arter Infection Control Report 2016, identified 33 cases of ammation of the ct which cases diarrhea, ninal pain). Daily tracking and	F 4	41	DEFICIENCY)		
		crease in UTI's was a "staff					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245257	B. WING			09/:	21/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ST OTTO	S CARE CENTER) SOUTHEAST 4TH STREET ITLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 9	F 4	141			
F 465 SS=D	with DON stated cu tracked by the facili "reeducate the staff Further, DON stated particular infections could track any tren A facility policy titled dated 3/1/2010, ide of the facilities infect procedures is to est infection control pro- safe, sanitary and of to help prevent the transmission of dise 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro-	ease and infection." L/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for	F 4	465			10/11/16
	by: Based on observat failed to ensure res in good repair for 3 including (RM-227, observed to have d On 9/19/16, at 3:52 to have gouges, mis	NT is not met as evidenced ion and interview, the facility ident living spaces were kept of 5 resident rooms (RM) RM-317, and RM-326) amaged walls. p.m. RM-227 was observed ssing paint, and exposed vall behind the resident's			F465-D It is our intent to provide a functional, sanitary, and comfortable environment for residents, staff and public. Rooms 227, 317, and 326 h been repaired as of 10/10/2016. A through of the facility was conducte remaining rooms and are in complia as of 10/11/2016. Education was provided to the Environmental Serv team members about observing,	e I the nave walk d of ance	

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UENTE	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · /	E SURVEY PLETED
		245257	B. WING		09/	21/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ST OTTO	OS CARE CENTER			920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 465	When interviewed of housekeeping (HK) and stated the wall resident's recliner. of scratches and th from the recliner hit wall was "not clean the exposed sheet repaired. HK-A sta was suppose to let when she saw dam she was aware that cleaned, either upo random deep clean housekeeping cheor repairs, however; if during the routine of unsure of the proce reporting these con department. During interview on of maintenance (DI marks penetrating the resident's reclin the scuff marks me and were caused b the wall. DM added surface," and he wall On 9/19/16, at 4:20 to have several are	on 9/21/16, at 8:58 a.m. -B observed wall in RM-227 did not look good behind the She stated the wall had a lot the sheet rock was exposed tting the wall. HK-A added the able" due to the scratches and rock and the wall needed be ted she was "not sure" if she maintenance know or not haged walls. HK-A also stated t when a room was deep on resident discharge or hing room rotation, cked the room for any needed wall damage was noted course of cleaning, she was as and she had not been her in RM-227. The DM stated pasured 32" (inches) x (by) 12" y the resident's recliner hitting I, "It is not a cleanable build repair the damaged wall. 0 p.m. RM-317 was observed tas of exposed sheet rock and	F 4	identifying, and communicating m repairs on 10/11/2016. Environm Services team members will docu items observed and identified as repair throughout their daily hous activities and document these iten the Maintenance Work Order Red Log located on each floor. Maint Director/designee will review the order request boards daily and m repairs accordingly, signing them repairs have been completed. Maintenance Director/designee w complete audits to ensure repairs been completed weekly for 4 wee followed then with monthly audits identification of scratched walls w discussed and reviewed at the ne Quality Council meeting with a su analysis of repairs made in subse meetings. Rooms will continue to visually inspected during semi-an deep cleaning schedule for long-t residents, as well as at time of re discharges. Corrective actions w completed by 10/11/2016.	ental ument needing ekeeping ms on quest renance work ake off when vill s have eks, . The vill be ext mmary equent o be nual erm sident	
	the resident's reclin the scuff marks me and were caused b the wall. DM added surface," and he wo On 9/19/16, at 4:20 to have several are missing paint on the recliner. When interviewed o observed wall in RM	her in RM-227. The DM stated easured 32" (inches) x (by) 12" y the resident's recliner hitting I, "It is not a cleanable ould repair the damaged wall. p.m. RM-317 was observed				

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		AND HUMAN SERVICES				FORM	11/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245257	B. WING			09/:	21/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ST ОТТС	OS CARE CENTER				20 SOUTHEAST 4TH STREET ITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	the wall. She furthe up, sheet rock was to be repainted. HK cleanable the way if During interview on stated there were m wall in RM-317 beh measured 20" x 7" a repaired due to the surface. On 9/19/16, at 6:34 to have missing pai the wall behind the When interviewed co observed wall in RM like the way the wal to be repaired. She up, had exposed sh repainted. HK-A fur cleanable the way if housekeeping deep and they also deep resident was discha deep cleaning, if ho work that needed to were to notify maint During interview on stated there were m RM-326 that measu additional area with x 6". DM stated, "T that needs to be rep would repair the da	 exposed, and the wall needed exposed, and the wall needed (-A added, "This surface is not t is right now." 9/21/16, at 11:21 a.m. DM nultiple scuffs marks on the ind the resident's recliner that and they needed to be area being a non-cleanable p.m. RM-326 was observed int and exposed sheet rock on resident's recliner. on 9/21/16, at 8:44 a.m. HK-A M-326 and stated she did not II looked and the wall needed stated the wall was scrapped neet rock, and needed to be ther stated, "This wall is not t is now." HK-A added, o cleans one room per day, clean resident rooms when a arged from the facility. When pusekeeping staff notice any o be done in the room, they tenance. 9/21/16, at 11:24 a.m. DM nultiple scuffs on the wall in ured 40" x 12" and an a scuff marks that measured 6" this is an uncleanable surface paired." DM also stated he 	F	465			

Facility ID: 00817

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/15/2016 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245257	B. WING	i		09/	21/2016
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ST ОТТС	OS CARE CENTER			-	20 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	that was kept at the environmental issue tell the nurses of ar the nurses were to work log. He furthe log on each floor da the log pertaining to wall damage, whee lights, light bulbs, o In a subsequent int DM stated it was hi housekeeping did ti was to report any n maintenance depar also be written on th he did not have a c for damages at spe of any facility policy resident rooms at s added he had a sol was to educate stat report for housekee a set distance for re sure recliner's were the walls to prevent	f the facility had a "work log" e nurse's station for es to be logged. Staff were to ny environmental concerns and document the concern on the er stated he checked the work aily for any concerns listed on the temperatures in the rooms, elchair concerns, beds, call or television concerns. Therefore on 9/21/16, at 11:41 is understanding that when their cleaning, housekeeping toted room damage to the rtment and the issue should he work log. DM further stated thecklist to check each room ecific times, nor was he aware of or maintenance to check specific time intervals. DM lution to the problem which ff on reporting issues, get a log eping to fill out, and make sure ecliner placement to make to kept a distance away from t damage.		465			

Facility ID: 00817

If continuation sheet Page 13 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES



PRINTED: 10/17/2016

245257 IAME OF PROVIDER OR SUPPLIER ST OTTOS CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	B. WING ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI		(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI		(X5)
		DEFICIENCY)	ROPRIATE	COMPLETION DATE
K 000 INITIAL COMMENTS	K 00	0		
FIRE SAFETY				
THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED As VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION. A Life Safety Code Survey was conducted 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				
substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR,				
Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY				
DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or		EPO	C	
Or by email to both: Marian.Whitney@state.mn.us				
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/12/201

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 A. BUILDING 01 - MAIN BUILDING 01 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COU 920 SOUTHEAST 4TH STREET ST OTTOS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR	(X3) DA CO 09 DE RECTION	0. 0938-0391 TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL ST OTTOS CARE CENTER 920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345 DECOMPERIS DI AN OF CORE)/22/2016
ST OTTOS CARE CENTER 920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345	RECTION	
	RECTION	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORH PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AI		(X5) COMPLETION DATE
K 000 Continued From page 1 K 000 and Angela.Kappenman@state.mn.us		
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 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 93 and had 		
a census of 78 at the time of the survey. DRM CMS-2567(02-99) Previous Versions Obsolete Event ID: CJD921 Facility ID: 00817 I	f continuation s	sheet Page 2 o

PRINTED: 10/17/2016

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
			PLE CONSTRUCTION G 01 - Main Building 01	(X3) DATE SURVEY COMPLETED	
	245257	B. WING		09	/22/2016
			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTHEAST 4TH STREET		
S CARE CENTER			LITTLE FALLS, MN 56345		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
Continued From pa	ge 2	K 00	0		
NOT MET as evide	nced by:				
		K 03	8		10/10/16
accessible at all tim 7.1. 19.2.1	nes in accordance with section				
Based on observa- facility failed to pro- accordance with the NFPA 101 "The Life (LSC) sections 19.2 MN State Fire Code practice could affect	tion and staff interview, the vide a means of egress in e following requirements of the e Safety Code" 2000 edition 2.1 and 7.2.1.6.1 and the 2007 e, Appendix I. This deficient ct 36 of 78 residents, as well as		arraigned exit access so that exi readily accessible at all times. E placards have been posted on re	ts are xiting equired	
Findings include:					
on the panic bar ur door will open in 15 doors located in the	til an alarm sound and that the 5 seconds for the exit stairwell e Elm, Oak and Pine Wings on				
	S CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa The requirement at NOT MET as evide NFPA 101 LIFE SA Exit access is arrar accessible at all tim 7.1. 19.2.1 This STANDARD i Based on observa facility failed to prov accordance with th NFPA 101 "The Life (LSC) sections 19.3 MN State Fire Code practice could affect an undetermined n Findings include: On facility tour betw on 09/22/2016, obs facility failed to prov on the panic bar ur door will open in 15 doors located in the the 3rd floor of the This deficient cond	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.2.1 and 7.2.1.6.1 and the 2007 MN State Fire Code, Appendix I. This deficient practice could affect 36 of 78 residents, as well as an undetermined number of staff, and visitors.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 2 K 00 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD K 03 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 K 03 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.2.1 and 7.2.1.6.1 and the 2007 MN State Fire Code, Appendix I. This deficient practice could affect 36 of 78 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 8:30 a.m. to 11:30 p.m. on 09/22/2016, observation revealed that the facility failed to provide placards directing to push on the panic bar until an alarm sound and that the door will open in 15 seconds for the exit stairwell doors located in the Elm, Oak and Pine Wings on the 3rd floor of the facility. This deficient condition was verified by the	SS CARE CENTER 920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WINTS BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLAN OF CORRECT (EACH CORRECTVE ACTION SHORE ACTION SHOW CROSS-REFERENCED TO THE APPRC DEFICIENCY) Continued From page 2 K 000 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD K 038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 19.2.1 K 038 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition facility failed to provide a means of egress in an undetermined number of staff, and visitors. K038-E It is our intent to provide arraigned exit access so that exit readily accessible at all times. E placards have been posted on re exit doors as of 10/10/2016 that staff and visitors. Findings include: On facility tour between 8:30 a.m. to 11:30 p.m. on 09/22/2016, observation revealed that the facility failed to provide placards directing to push on the panic bar until an alarm sound and that the door socated in the Elm, Oak and Pine Wings on the 3rd floor of the facility. This deficient condition was verified by the His eficient condition was verified by the	S CARE CENTER 920 SOUTHEAST 4TH STREET LITLE FALLS, MU 65345 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED 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) Continued From page 2 K 000 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD K 038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1 . 19.2.1 K 038 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.2.1 and 7.2.1.6.1 and the 2007 MN State Fire Code, Appendix I. This deficient practice could affect 36 of 78 residents, as well as an undetermined number of staff, and visitors. K038-E It is our intent to provide arraigned exit access so that exits are readily accessible at all times. Exiting placards have been posted on required exit doors as of 10/10/2016 that direct staff and visitors. Findings include: On facility tour between 8:30 a.m. to 11:30 p.m. on 09/22/2016, observation revealed that the facility failed to provide placards directing to push on the partic bar until an alarm sound and that the door will open in 15 seconds for the exit staitwell doors located in the Em, Oak and Pine Wings on the 3rd floor of the facility. This deficient condition was verified by the Hereit Account Account Account Acces Acce



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted October 4, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5257026

Dear Mr. Bernander:

The above facility was surveyed on September 19, 2016 through September 22, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute

after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Teresa Ament at 218-302-6151.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kumala Piske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

Enclosure(s)

cc: Licensing and Certification File

Minnesc	ota Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00817	B. WING		09/2	21/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST OTTO	OS CARE CENTER		HEAST 4TH ALLS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 10/12/16

Electronically Signed STATE FORM

If continuation sheet 1 of 16

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00817	B. WING		09/	09/21/2016	
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE. ZIP CODE			
			THEAST 4TH S				
отто та	OS CARE CENTER		ALLS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 000	Continued From pa	ge 1	2 000				
	you electronically. <i>J</i> is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, the corrected prior to el Minnesota Departm On September 19-2 Department's staff, the following correc Please indicate in y correction that you and identify the date Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state stat listed in the "Summ column and replace the correction order the findings which a statute after the stat as evidence by." Fo are the Suggested I Time period for Cor PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA	21, 2016, surveyors of this visited the above provider and tion orders are issued. our electronic plan of have reviewed these orders, e when they will be completed. the tof Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of this column also includes are in violation of the state tement, "This Rule is not met ollowing the surveyors findings Method of Correction and rection. RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.					

CJD911

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIP	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		:	COMPLETED	
		00817	B. WING		09/21/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
от отто	S CARE CENTER		THEAST 4TH FALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
2 565	Continued From pa	ge 2	2 565			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565		10/18/1	
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observati review, the facility f hygiene as directed	ent is not met as evidenced ion, interview and document ailed to complete personal I by the plan of care for 1 of 3 iewed for activities of daily		0565 - Corrected		
	Findings include:					
	8/30/16, identified of dementia and hear	imum Data Set (MDS) dated diagnoses that included t failure. The MDS further ired extensive assistance with				
	comb/brush hair, p	dated 6/7/16, directed staff to rovide oral cares, wash dorant, wash hands/face, wash ovide perineal care.	ו			
		rm care plan dated 9/7/16, oming, staff: "does everything s face.")			
	was seated in her v of the television. S a dark substance u	on 9/20/16, at 9:22 a.m. R55 vheelchair in her room in front everal of R55's fingernails had nderneath them. At 3:18 p.m. erved in her room in front of	I			

CJD911

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00817			09/	09/21/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
эт отто	S CARE CENTER		THEAST 4TH S ALLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE	
2 565	Continued From page 3		2 565			
	the television, with the dark colored substance visible underneath several fingernails. R55 was observed again on 9/21/16, at 9:48 a.m. in her room, with the dark colored substance visible underneath several fingernails.					
	nursing assistant (N R55 with personal I stated staff provide but se can wash he the washcloth. NA- under any resident' them and provide n observed R55 in the table, and verified t	on 9/21/16, at 8:42 a.m. NA)-A stated NA-B assisted hygiene this morning. NA-A the majority of cares for R55, er hands after staff hand her -A stated if debris was noted s fingernails, he would soak hail care. At this time NA-A e dining room, sitting at the here was a dark substance gernails on both hands, and h care of.				
		on 9/21/16, at 9:24 a.m. NA-C provided on bath days.				
	stated she is a nurs provides range of n NA-B verified she c cares this morning, R55 to wash her ov cares were comple hands, but denied r beneath R55's nails "probably would ha returned at 11:50 a bath on Wednesda getting a bath later, provided. NA-B ve	on 9/21/16, at 11:38 a.m. NA-B sing assistant and also notion (ROM) to residents. did assist R55 with personal , and provided a washcloth for wn face and hands. After te, ROM was provided on her noticing any dark substance s, and if it was noted she ve cleaned them." NA-B .m., stating R55 receives a y evenings, so would be , when nail care would be rified it would not be sanitary substance beneath the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				· · · · · · · · · · · · · · · · · · ·			
		00817	B. WING		09/	21/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
отто	S CARE CENTER		THEAST 4TH S FALLS, MN 56				
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 565	Continued From pa	age 4	2 565				
	hands soaking in a and licensed practi present in the room were noted on the this time, LPN-A ve substance beneath hands prior to being care is provided on expectation that sta fingernails if they a Facility policy titled effective 3/1/10, ide of care is the respon planning, implement	air in her room, with both sudsy water filled basin. NA-A cal nurse (LPN)-A were both n, and a nail file and clipper table in front of the basin. At erified R55 had a dark a several fingernails on both g soaked. LPN-A stated nail bath days, but it is her aff are cleaning resident's re noted to be dirty. Care Management dated entified coordination of the plar onsibility of nursing: however, ntation, and evaluation require y each discipline rendering					
	director of nursing educate nursing sta a residents care pla compliance.	THOD OF CORRECTION: The (DON) or designee could aff regarding implementation o an, then audit to ensure R CORRECTION: Twenty-one					
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			10/18/16	
	comprehensive res home must ensure B. a resident who activities of daily liv	o is unable to carry out ring receives the necessary n good nutrition, grooming,					

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00817	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ат отто	S CARE CENTER		THEAST 4TH ALLS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 5	2 920			
	by: Based on observat review, the facility f provided to 1 of 3 r	ent is not met as evidenced ion, interview and document ailed to ensure nail care was esidents (R55) reviewed for ing (ADL) whom was for care.		0920 - Corrected		
	Findings include:					
	8/30/16, identified of dementia and hear identified R55 requ personal hygiene. Interview for Menta	himum Data Set (MDS) dated diagnoses that included t failure. The MDS further ired extensive assistance with It also identified the Brief Il Status (BIMS, as screening hine cognition) R55 to have apairment.				
	comb/brush hair, p glasses, apply deo	dated 6/7/16, directed staff to rovide oral cares, wash dorant, wash hands/face, wash ovide perineal care.				
		rm care plan dated 9/7/16, ooming, staff: "does everything s face."				
	was seated in her v of the television. Se a dark substance u R55 was again obs the television, with visible underneath observed again on	on 9/20/16, at 9:22 a.m. R55 wheelchair in her room in front everal of R55's fingernails had inderneath them. At 3:18 p.m. erved in her room in front of the dark colored substance several fingernails. R55 was 9/21/16, at 9:48 a.m. in her a colored substance visible I fingernails.				

Minneso	ota Department of He	ealth	1			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.			
		00817	B. WING		09/21/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	OS CARE CENTER	920 SOU	THEAST 4TH	STREET		
31 0110	05 CARE CENTER	LITTLE F	ALLS, MN 56	345		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
2 920	Continued From pa	age 6	2 920			
		-				
		NA)-A stated NA-B assisted				
		hygiene this morning. NA-A				
		the majority of cares for R55,				
		er hands after staff hand her A stated if debris was noted				
		's fingernails, he would soak nail care. At this time NA-A				
		e dining room, sitting at the				
		here was a dark substance				
		gernails on both hands, and				
	this would be taken					
	When interviewed a	on 9/21/16, at 9:24 a.m. NA-C				
		provided on bath days.				
	When interviewed (on 9/21/16, at 11:38 a.m. NA-E	2			
		sing assistant and also	,			
		notion (ROM) to residents.				
		did assist R55 with personal				
		, and provided a washcloth for				
		wn face and hands. After cares				
		OM was provided on her hands.				
		any dark substance beneath	,			
		t was noted she "probably				
		d them." NA-B returned at				
		R55 receives a bath on				
		igs, so would be getting a bath				
		e would be provided. NA-B				
		t be sanitary to eat with a				
		eneath the fingernails.				
	On 9/21/16 at 12:2	27 p.m. R55 was observed				
		air in her room, with both				
		sudsy water filled basin. NA-A				
		cal nurse (LPN)-A were both	*			
		n, and a nail file and clipper				
		table in front of the basin. At				
		erified R55 had a dark				
		several fingernails on both				
		g soaked. LPN-A stated nail				
	epartment of Health	g countrainen en reviertou num	II IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00817	B. WING		09/	09/21/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
sт отто	OS CARE CENTER		THEAST 4TH S				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 920	Continued From pa	age 7	2 920				
		bath days, but it is her aff are cleaning resident's re noted to be dirty.					
	/Skills dated effecti	Activities of Daily Living (ADL) ve 9/14/10, identified under elf-image is maintained.					
	director of nursing	THOD OF CORRECTION: The could monitor for compliance staff in providing resident d for nail care.	•				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One	,				
21390	MN Rule 4658.080	0 Subp. 4 A-I Infection Control	21390			10/18/16	
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreak C. isolation and reduce risk of trans D. in-service e prevention and com E. a resident h immunization progr defined in part 465 procedures of resid the prevention and F. the develop employee health po	and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in r detection, investigation, and s of infectious diseases; d precautions systems to smission of infectious agents; ducation in infection trol; ealth program including an ram, a tuberculosis program as i8.0810, and policies and dent care practices to assist in treatment of infections; ment and implementation of policies and infection control a tuberculosis program as					

	ta Department of He						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURV COMPLETED		
		00817	B. WING		09/21/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
отто та	S CARE CENTER		THEAST 4TH				
			ALLS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COM	(X5) MPLET DATE	
21390	Continued From pa	age 8	21390				
	H. a system fo products which affe disinfectants, antis incontinence produ I. methods for						
	by: Based on interview facility failed to dev program to include collected infection transmission to oth	ent is not met as evidenced v and document review, the velop an infection control the trending and analysis of data to reduce the risk of her residents in the facility. This o affect all 79 residents whom ty.		1390 - Corrected			
	Findings include;						
	dated June 2016, in infections: 3 Clostri infections (infection causes inflammatic can cause flu-like s unknown respirato infections (UTI). The specific resident, s and where the infer- resided in, the orgation infection was resold the collected data to infectious disease	Antibiotic Tracking Record dentified the following idium Difficile (C-Diff) in caused by bacteria which on of the large intestine and symptoms), 8 cases of ry infection and 6 urinary track he report identified each ymptoms, treatment, isolation ction acquired information. The tify what room the resident anism identified and when the ved. There was no analysis of to determine if potentially was spreading in the facility or f was deemed necessary.					
	dated July 2016, id	Antibiotic Tracking Record lentified the following					
nesota De	epartment of Health A		6899	CJD911	If continuation she	ot 9	

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00817	B. WING		09/21/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
ат отто	OS CARE CENTER		THEAST 4TH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	infections: 5 UTI's, of the outermost la and the inner surfa and 2 methicillin re (MRSA, a bacteria antibiotics). The red the resident resided when the infection analysis of the colle potentially infection the facility or if edu necessary. A facility Infection/A Dated August 2016 infections, 13 UTI's staphylococcus ski identify what room organism identified resolved. There wa data to determine i was deemed neces	2 conjunctivitis (inflammation yer of the white part of the eye ce of the eyelid), 2 pneumonia sistant staphylococcus aureus resistant to several cord did not identify what room d in, the organism identified, or was resolved. There was no ected data to determine if is disease was spreading in cation to staff was deemed Antibiotic Tracking Record 5, identified the following 5, 1 conjunctivitis, and 1 in infection. The record did not the resident resided in, the I and when the infection was as no analysis of the collected f potentially infectious disease ne facility or if education to staff				
	Dated September 2 infections: 3 bronch and 1 conjunctivitis what room the residentified and wher There was no analy determine if potent	2016, identified the following hitis, 2 UTI's, 1 pneumonia, s. The record did not identify dent resided in, the organism in the infection was resolved. ysis of the collected data to ially infectious disease was cility or if education to staff was	5			
	for January-March gastroenteritis (infla gastrointestinal trad	uarter Infection Control Report 2016, identified 33 cases of ammation of the ct which cases diarrhea, minal pain). Daily tracking and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00817	B. WING		09/	09/21/2016	
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
от отто	S CARE CENTER		THEAST 4TH S				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21390	Continued From pa	age 10	21390				
	hand washing audi	ts were completed.					
	Report for April-Jur higher rate of respi particular lane and depending on their increase in UTI's h an infection control precautions, provid hygiene. When interviewed director of nursing responsible for the collected by the fac reviewed it on a we was analyzed for tr incidents identified the identified organ	and quarter Infection Control the 2016 identified there was a fratory infections down one residents were isolated symptoms. There was also an ouse wide and staff were given l inservice on standard ling proper peri-care and hand on 9/21/16, at 11:21 a.m. (DON) stated she was program. The infection data cility nursing staff and the DON eekly basis. The information rends based on the number of for each infection, but not by hism. The DON stated in the ary 2016, she discussed with					
	organisms from uri trends as there had the facility. In June to nursing assistan and preventing the	or the importance of culturing ine cultures and monitoring d been an increase in UTI's in 2016, education was provided ts on handwashing, pericare spread of infection because crease in UTI's was a "staff					
	with DON stated cu tracked by the facil "reeducate the staf Further, DON state particular infections	terview on 9/21/16 at 3:35 p.m. ultures were not currently being ity and she needed to if" on the infection control logs. ed identifying the organism for s would be beneficial so she nds within the facility.					
		d, "Infection Control Program" entified, "the primary purpose					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00817	B. WING		09/21/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ст отто	OS CARE CENTER		THEAST 4TH ALLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21390		age 11 ction control policies and	21390			
	procedures is to es infection control pro safe, sanitary and o to help prevent the	tablish and maintain an ogram designed to provide a comfortable environments and				
	The facility adminis review and revise p relation to the facili The administrator o education to all fac	THOD OF CORRECTION: strator or designee could policies and procedures in ty's infection control program. or designee could provide ility staff on infection control. or designee could do dits for compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685			10/11/16
	including walls, floc systems, and equip continuous state of with regard to the h well-being of the re	olant. The physical plant, brs, ceilings, all furnishings, oment must be kept in a good repair and operation health, comfort, safety, and esidents according to a written be and repair program.				
	by: Based on observat failed to ensure res in good repair for 3	ent is not met as evidenced ion and interview, the facility ident living spaces were kept of 5 resident rooms (RM) RM-317, and RM-326) lamaged walls.		1685 - Corrected		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00817	B. WING	B. WING		09/21/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE, ZIP CODE				
ст отто	OS CARE CENTER		THEAST 4TH : ALLS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
21685	Continued From pa	lge 12	21685				
	to have gouges, mi	p.m. RM-227 was observed ssing paint, and exposed vall behind the resident's					
	housekeeping (HK) and stated the wall resident's recliner. of scratches and th from the recliner hit wall was "not clean the exposed sheet repaired. HK-A sta was suppose to let when she saw dam she was aware that cleaned, either upo random deep clean housekeeping cheo repairs, however; if during the routine of unsure of the proce reporting these con department.	cked the room for any needed wall damage was noted course of cleaning, she was ess and she had not been acerns to the maintenance					
	of maintenance (DI marks penetrating the resident's recline the scuff marks me and were caused b the wall. DM added surface," and he wo On 9/19/16, at 4:20	 9/21/16, at 11:14 a.m. director M) stated there were scuff the first layer of paint behind her in RM-227. The DM stated heasured 32" (inches) x (by) 12" y the resident's recliner hitting I, "It is not a cleanable build repair the damaged wall. p.m. RM-317 was observed 					
		as of exposed sheet rock and e wall behind the resident's					

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
		00817	B. WING		09/	9/21/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
отто та	OS CARE CENTER		THEAST 4TH ALLS, MN 56				
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	COMPLET DATE	
21685	Continued From pa	age 13	21685				
	When interviewed observed wall in RI wall was caused by the wall. She further up, sheet rock was to be repainted. Hk cleanable the way in During interview or stated there were reall in RM-317 ber measured 20" x 7" repaired due to the surface. On 9/19/16, at 6:34 to have missing pathe wall behind the When interviewed observed wall in RI like the way the wat to be repaired. She up, had exposed so repainted. HK-A fur cleanable the way in housekeeping deep and they also deep resident was dischadeep cleaning, if he work that needed to were to notify main During interview or stated there were re RM-326 that meas additional area with x 6". DM stated, "T	on 9/21/16, at 8:52 a.m. HK-A M-317 and stated the damaged y the resident's recliner hitting er stated the wall was scraped exposed, and the wall needed K-A added, "This surface is not it is right now." n 9/21/16, at 11:21 a.m. DM multiple scuffs marks on the nind the resident's recliner that and they needed to be area being a non-cleanable A p.m. RM-326 was observed int and exposed sheet rock on resident's recliner. on 9/21/16, at 8:44 a.m. HK-A M-326 and stated she did not II looked and the wall needed e stated the wall was scrapped heet rock, and needed to be rther stated, "This wall is not it is now." HK-A added, p cleans one room per day, o clean resident rooms when a arged from the facility. When pusekeeping staff notice any o be done in the room, they					

	ota Department of He					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00817	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
			THEAST 4TH			
STOTIC	DS CARE CENTER	LITTLE F	ALLS, MN 56	345		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 14	21685			
	stated each floor of that was kept at the environmental issue tell the nurses of an the nurses were to work log. He furthe log on each floor da the log pertaining to wall damage, whee lights, light bulbs, o	on 9/21/16, at 11:09 a.m. DM the facility had a "work log" e nurse's station for es to be logged. Staff were to ny environmental concerns and document the concern on the er stated he checked the work aily for any concerns listed on o temperatures in the rooms, lchair concerns, beds, call r television concerns. erview on 9/21/16, at 11:41 s understanding that when				
	housekeeping did th was to report any n maintenance depar also be written on th he did not have a ch for damages at spe of any facility policy resident rooms at s added he had a sol was to educate stat report for housekee a set distance for re	heir cleaning, housekeeping oted room damage to the tment and the issue should he work log. DM further stated hecklist to check each room wrific times, nor was he aware for maintenance to check pecific time intervals. DM ution to the problem which if on reporting issues, get a log eping to fill out, and make sure ecliner placement to make a kept a distance away from				
	A facility policy on b requested, but not p	ouilding maintenance was provided.				
	The director of nurs develop a maintena damaged walls are clean, homelike env designee could edu	HOD OF CORRECTION: sing (DON) or designee could ance program to ensure repaired to maintain a safe, vironment. The DON or icate all appropriate staff on ould develop monitoring				

TATEMENT OF DEFICIENCIES (X1) PROV ND PLAN OF CORRECTION IDENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00917	B. WING		00/	21/2016	
	PROVIDER OR SUPPLIER	00817	B. WING 0				
	S CARE CENTER	920 SOL	JTHEAST 4TH	STREET			
		ATEMENT OF DEFICIENCIES	FALLS, MN 56	945 PROVIDER'S PLAN OF		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE	
21685	Continued From pa	age 15	21685				
	systems to ensure	ongoing compliance.					
	TIME PERIOD FOI Twenty-One (21) D						