DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CJD9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00817

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245257**

2.STATE VENDOR OR MEDICAID NO.
(L2) **835542800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OTTOS CARE CENTER**
(L4) **920 SOUTHEAST 4TH STREET**
(L5) **LITTLE FALLS, MN** (L6) **56345**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/17/2008**

6. DATE OF SURVEY **11/07/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **93** (L18)

13.Total Certified Beds **93** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Teresa Ament, Unit Supervisor — 11/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/15/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/18/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/15/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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.

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

MDH
Minnesota
Department
of Health

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.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245257 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0312	Correction	ID Prefix F0441	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.65	Completed
LSC	10/12/2016	LSC	10/12/2016	LSC	10/12/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/12/2016	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		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) PK/KJ	DATE 11/15/2016	SIGNATURE OF SURVEYOR 29433	DATE 11/07/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
9/21/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245257	A. Building 01 - MAIN BUILDING 01 B. Wing	10/27/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 10/10/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 11/15/2016	SIGNATURE OF SURVEYOR 29433	DATE 10/27/2016
REVIEWED BY CMS RO ☐	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? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: CJD9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00817

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245257**

2.STATE VENDOR OR MEDICAID NO.
(L2) **835542800**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OTTOS CARE CENTER**
(L4) **920 SOUTHEAST 4TH STREET**
(L5) **LITTLE FALLS, MN** (L6) **56345**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/17/2008**

6. DATE OF SURVEY **09/21/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **93** (L18)

13.Total Certified Beds **93** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	93			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Annette Truebenbach, HFE NE II — 10/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/14/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1983
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/15/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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:

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

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

Remedies - 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;

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

Informal Dispute Resolution - 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: Teresa.Ament@state.mn.us
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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,

Kamala 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: Kamala.Fiske-Downing@state.mn.us

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245257	A. BUILDING _____ B. WING _____	09/21/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete personal hygiene as directed by the plan of care for 1 of 3 residents (R55) reviewed for activities of daily living (ADL). Findings include: R55's quarterly Minimum Data Set (MDS) dated 8/30/16, identified diagnoses that included dementia and heart failure. The MDS further identified R55 required extensive assistance with personal hygiene.	F 282	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 staff, R55□s fingernails were cleaned on 9/22/2016. Education to team members regarding the need to review and follow 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 also reviewed with team members by 10/18/2016. DON/designee will assess all	10/24/16

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

Electronically Signed | 10/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245257	A. BUILDING _____ B. WING _____	09/21/2016

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

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F 282	Continued From page 1 R55's plan of care dated 6/7/16, directed staff to comb/brush hair, provide oral cares, wash glasses, apply deodorant, wash hands/face, wash underarms, and provide perineal care. R55's ADL short term care plan dated 9/7/16, identified under grooming, staff: "does everything but resident washes face." During observation on 9/20/16, at 9:22 a.m. R55 was seated in her wheelchair in her room in front of the television. Several of R55's fingernails had a dark substance underneath them. At 3:18 p.m. R55 was again observed in her room in front of 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. When interviewed on 9/21/16, at 8:42 a.m. nursing assistant (NA)-A stated NA-B assisted R55 with personal hygiene this morning. NA-A stated staff provide the majority of cares for R55, but se can wash her hands after staff hand her the washcloth. NA-A stated if debris was noted under any resident's fingernails, he would soak them and provide nail care. At this time NA-A observed R55 in the dining room, sitting at the table, and verified there was a dark substance beneath several fingernails on both hands, and this would be taken care of. When interviewed on 9/21/16, at 9:24 a.m. NA-C stated nail care is provided on bath days. When interviewed on 9/21/16, at 11:38 a.m. NA-B stated she is a nursing assistant and also	F 282	residents needing nail care with needed ADL□s provided by 10/18/16. DON/designee will complete audits to ensure the ADL□s have been provided per the care plan for 4 weeks, followed then with monthly audits. Corrective action will be completed by 10/24/16.	

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F 282	Continued From page 2 provides range of motion (ROM) to residents. NA-B verified she did assist R55 with personal cares this morning, and provided a washcloth for R55 to wash her own face and hands. After cares were complete, ROM was provided on her hands, but denied noticing any dark substance beneath R55's nails, and if it was noted she "probably would have cleaned them." NA-B returned at 11:50 a.m., stating R55 receives a bath on Wednesday evenings, so would be getting a bath later, when nail care would be provided. NA-B verified it would not be sanitary to eat with a brown substance beneath the fingernails. On 9/21/16, at 12:27 p.m. R55 was observed sitting in a wheelchair in her room, with both hands soaking in a sudsy water filled basin. NA-A and licensed practical nurse (LPN)-A were both present in the room, and a nail file and clipper were noted on the table in front of the basin. At this time, LPN-A verified R55 had a dark substance beneath several fingernails on both hands prior to being soaked. LPN-A stated nail care is provided on bath days, but it is her expectation that staff are cleaning resident's fingernails if they are noted to be dirty. Facility policy titled Care Management dated effective 3/1/10, identified coordination of the plan of care is the responsibility of nursing: however, planning, implementation, and evaluation require joint participation by each discipline rendering service.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		10/24/16

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F 312	Continued From page 3 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided to 1 of 3 residents (R55) reviewed for activities of daily living (ADL) whom was dependent on staff for care. Findings include: R55's quarterly Minimum Data Set (MDS) dated 8/30/16, identified diagnoses that included dementia and heart failure. The MDS further identified R55 required extensive assistance with personal hygiene. It also identified the Brief Interview for Mental Status (BIMS, as screening tool used to determine cognition) R55 to have severe cognitive impairment. R55's plan of care dated 6/7/16, directed staff to comb/brush hair, provide oral cares, wash glasses, apply deodorant, wash hands/face, wash underarms, and provide perineal care. R55's ADL short term care plan dated 9/7/16, identified under grooming, staff: "does everything but resident washes face." During observation on 9/20/16, at 9:22 a.m. R55 was seated in her wheelchair in her room in front of the television. Several of R55's fingernails had a dark substance underneath them. At 3:18 p.m. R55 was again observed in her room in front of	F 312	F312-D It is our intent to provide ADL care to residents in need of services. Upon discussion with surveyors and observation of R55□s fingernails by staff, R55□s fingernails were cleaned. Education to team members regarding the need to review and follow resident care plans was completed by 10/18/2016. Current nail care policy requiring nails to be cleaned at a minimum weekly, or as needed was also reviewed with team members by 10/18/2016. DON/designee will assess all residents for nail care by 10/18/16. DON/designee will complete audits to ensure the ADL□s have been provided per the care plan for 4 weeks, followed then with monthly audits. Corrective action will be completed by 10/24/16.	

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F 312	Continued From page 4	F 312		

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.

When interviewed on 9/21/16, at 8:42 a.m. nursing assistant (NA)-A stated NA-B assisted R55 with personal hygiene this morning. NA-A stated staff provide the majority of cares for R55, but se can wash her hands after staff hand her the washcloth. NA-A stated if debris was noted under any resident's fingernails, he would soak them and provide nail care. At this time NA-A observed R55 in the dining room, sitting at the table, and verified there was a dark substance beneath several fingernails on both hands, and this would be taken care of.

When interviewed on 9/21/16, at 9:24 a.m. NA-C stated nail care is provided on bath days.

When interviewed on 9/21/16, at 11:38 a.m. NA-B stated she is a nursing assistant and also provides range of motion (ROM) to residents. NA-B verified she did assist R55 with personal cares this morning, and provided a washcloth for R55 to wash her own face and hands. After cares were complete, ROM was provided on her hands, but denied noticing any dark substance beneath R55's nails, and if it was noted she "probably would have cleaned them." NA-B returned at 11:50 a.m., stating R55 receives a bath on Wednesday evenings, so would be getting a bath later, when nail care would be provided. NA-B verified it would not be sanitary to eat with a brown substance beneath the fingernails.

On 9/21/16, at 12:27 p.m. R55 was observed

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F 312	Continued From page 5 sitting in a wheelchair in her room, with both hands soaking in a sudsy water filled basin. NA-A and licensed practical nurse (LPN)-A were both present in the room, and a nail file and clipper were noted on the table in front of the basin. At this time, LPN-A verified R55 had a dark substance beneath several fingernails on both hands prior to being soaked. LPN-A stated nail care is provided on bath days, but it is her expectation that staff are cleaning resident's fingernails if they are noted to be dirty. Facility policy titled Activities of Daily Living (ADL) /Skills dated effective 9/14/10, identified under hygiene, resident self-image is maintained.	F 312		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		10/18/16

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F 441	Continued From page 6 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an infection control program to include the trending and analysis of collected infection data to reduce the risk of transmission to other residents in the facility. This had the potential to affect all 79 residents whom resided in the facility. Findings include; A facility Infection/Antibiotic Tracking Record dated June 2016, identified the following infections: 3 Clostridium Difficile (C-Diff) infections (infection caused by bacteria which causes inflammation of the large intestine and can cause flu-like symptoms), 8 cases of unknown respiratory infection and 6 urinary track infections (UTI). The report identified each specific resident, symptoms, treatment, isolation and where the infection acquired information. The	F 441	F441-F It is our intent to maintain an infection control program. DON/designee reviewed current procedures and education to team members will be completed by 10/18/16. DON/designee will review the Infection/Antibiotic Tracking Record weekly ensuring tracking data on record is complete allowing for an analysis to be completed to identify potential cause and/or spreading of infection. Analysis of data and trends will continue weekly by DON/designee followed by appropriate interventions and team member education based on data reviewed. Corrective action will be completed by 10/18/16.	

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F 441	Continued From page 7	F 441		

record did not identify what room the resident resided in, the organism identified and when the infection was resolved. There was no analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to staff was deemed necessary.

A facility Infection/Antibiotic Tracking Record dated July 2016, identified the following infections: 5 UTI's, 2 conjunctivitis (inflammation of the outermost layer of the white part of the eye and the inner surface of the eyelid), 2 pneumonia and 2 methicillin resistant staphylococcus aureus (MRSA, a bacteria resistant to several antibiotics). The record did not identify what room the resident resided in, the organism identified, or when the infection was resolved. There was no analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to staff was deemed necessary.

A facility Infection/Antibiotic Tracking Record Dated August 2016, identified the following infections, 13 UTI's, 1 conjunctivitis, and 1 staphylococcus skin infection. The record did not identify what room the resident resided in, the organism identified and when the infection was resolved. There was no analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to staff was deemed necessary.

A facility Infection/Antibiotic Tracking Record Dated September 2016, identified the following infections: 3 bronchitis, 2 UTI's, 1 pneumonia, and 1 conjunctivitis. The record did not identify what room the resident resided in, the organism identified and when the infection was resolved.

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F 441	Continued From page 8 There was no analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to staff was deemed necessary. Review of a first quarter Infection Control Report for January-March 2016, identified 33 cases of gastroenteritis (inflammation of the gastrointestinal tract which cases diarrhea, vomiting and abdominal pain). Daily tracking and hand washing audits were completed. Review of the second quarter Infection Control Report for April-June 2016 identified there was a higher rate of respiratory infections down one particular lane and residents were isolated depending on their symptoms. There was also an increase in UTI's house wide and staff were given an infection control inservice on standard precautions, providing proper peri-care and hand hygiene. When interviewed on 9/21/16, at 11:21 a.m. director of nursing (DON) stated she was responsible for the program. The infection data collected by the facility nursing staff and the DON reviewed it on a weekly basis. The information was analyzed for trends based on the number of incidents identified for each infection, but not by the identified organism. The DON stated in the beginning of January 2016, she discussed with the medical director the importance of culturing organisms from urine cultures and monitoring trends as there had been an increase in UTI's in the facility. In June 2016, education was provided to nursing assistants on handwashing, pericare and preventing the spread of infection because she believed the increase in UTI's was a "staff education issue".	F 441		

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F 441	Continued From page 9 In a subsequent interview on 9/21/16 at 3:35 p.m. with DON stated cultures were not currently being tracked by the facility and she needed to "reeducate the staff" on the infection control logs. Further, DON stated identifying the organism for particular infections would be beneficial so she could track any trends within the facility. A facility policy titled, "Infection Control Program" dated 3/1/2010, identified, "the primary purpose of the facilities infection control policies and procedures is to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environments and to help prevent the development and transmission of disease and infection."	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident living spaces were kept in good repair for 3 of 5 resident rooms (RM) including (RM-227, RM-317, and RM-326) observed to have damaged walls. On 9/19/16, at 3:52 p.m. RM-227 was observed to have gouges, missing paint, and exposed sheet rock on the wall behind the resident's recliner.	F 465	F465-D It is our intent to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Rooms 227, 317, and 326 have been repaired as of 10/10/2016. A walk through of the facility was conducted of remaining rooms and are in compliance as of 10/11/2016. Education was provided to the Environmental Services team members about observing,	10/11/16

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F 465	Continued From page 10 When interviewed on 9/21/16, at 8:58 a.m. housekeeping (HK)-B observed wall in RM-227 and stated the wall did not look good behind the resident's recliner. She stated the wall had a lot of scratches and the sheet rock was exposed from the recliner hitting the wall. HK-A added the wall was "not cleanable" due to the scratches and the exposed sheet rock and the wall needed be repaired. HK-A stated she was "not sure" if she was suppose to let maintenance know or not when she saw damaged walls. HK-A also stated she was aware that when a room was deep cleaned, either upon resident discharge or random deep cleaning room rotation, housekeeping checked the room for any needed repairs, however; if wall damage was noted during the routine course of cleaning, she was unsure of the process and she had not been reporting these concerns to the maintenance department. During interview on 9/21/16, at 11:14 a.m. director of maintenance (DM) stated there were scuff marks penetrating the first layer of paint behind the resident's recliner in RM-227. The DM stated the scuff marks measured 32" (inches) x (by) 12" and were caused by the resident's recliner hitting the wall. DM added, "It is not a cleanable surface," and he would repair the damaged wall. On 9/19/16, at 4:20 p.m. RM-317 was observed to have several areas of exposed sheet rock and missing paint on the wall behind the resident's recliner. When interviewed on 9/21/16, at 8:52 a.m. HK-A observed wall in RM-317 and stated the damaged wall was caused by the resident's recliner hitting	F 465	identifying, and communicating needed repairs on 10/11/2016. Environmental Services team members will document items observed and identified as needing repair throughout their daily housekeeping activities and document these items on the Maintenance Work Order Request Log located on each floor. Maintenance Director/designee will review the work order request boards daily and make repairs accordingly, signing them off when repairs have been completed. Maintenance Director/designee will complete audits to ensure repairs have been completed weekly for 4 weeks, followed then with monthly audits. The identification of scratched walls will be discussed and reviewed at the next Quality Council meeting with a summary analysis of repairs made in subsequent meetings. Rooms will continue to be visually inspected during semi-annual deep cleaning schedule for long-term residents, as well as at time of resident discharges. Corrective actions will be completed by 10/11/2016.	

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the wall. She further stated the wall was scraped up, sheet rock was exposed, and the wall needed to be repainted. HK-A added, "This surface is not cleanable the way it is right now."

During interview on 9/21/16, at 11:21 a.m. DM stated there were multiple scuffs marks on the wall in RM-317 behind the resident's recliner that measured 20" x 7" and they needed to be repaired due to the area being a non-cleanable surface.

On 9/19/16, at 6:34 p.m. RM-326 was observed to have missing paint and exposed sheet rock on the wall behind the resident's recliner.

When interviewed on 9/21/16, at 8:44 a.m. HK-A observed wall in RM-326 and stated she did not like the way the wall looked and the wall needed to be repaired. She stated the wall was scrapped up, had exposed sheet rock, and needed to be repainted. HK-A further stated, "This wall is not cleanable the way it is now." HK-A added, housekeeping deep cleans one room per day, and they also deep clean resident rooms when a resident was discharged from the facility. When deep cleaning, if housekeeping staff notice any work that needed to be done in the room, they were to notify maintenance.

During interview on 9/21/16, at 11:24 a.m. DM stated there were multiple scuffs on the wall in RM-326 that measured 40" x 12" and an additional area with scuff marks that measured 6" x 6". DM stated, "This is an uncleanable surface that needs to be repaired." DM also stated he would repair the damaged wall.

When interviewed on 9/21/16, at 11:09 a.m. DM

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F 465	Continued From page 12	F 465		

stated each floor of the facility had a "work log" that was kept at the nurse's station for environmental issues to be logged. Staff were to tell the nurses of any environmental concerns and the nurses were to document the concern on the work log. He further stated he checked the work log on each floor daily for any concerns listed on the log pertaining to temperatures in the rooms, wall damage, wheelchair concerns, beds, call lights, light bulbs, or television concerns.

In a subsequent interview on 9/21/16, at 11:41 DM stated it was his understanding that when housekeeping did their cleaning, housekeeping was to report any noted room damage to the maintenance department and the issue should also be written on the work log. DM further stated he did not have a checklist to check each room for damages at specific times, nor was he aware of any facility policy for maintenance to check resident rooms at specific time intervals. DM added he had a solution to the problem which was to educate staff on reporting issues, get a log report for housekeeping to fill out, and make sure a set distance for recliner placement to make sure recliner's were kept a distance away from the walls to prevent damage.

A facility policy on building maintenance was requested, but not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245257	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/22/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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 Or by email to both: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/12/2016

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.

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	245257	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2016**

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

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K 000	Continued From page 1 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.	K 000		

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	245257	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/22/2016**

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K 000	Continued From page 2	K 000		
K 038 SS=E	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. 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 Maintenance Staff Member.	K 038	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.	10/10/16

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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,

Kamala 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: Kamala.Fiske-Downing@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00817	A. BUILDING: _____ B. WING _____	09/21/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On September 19-21, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 565	Continued From page 2	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete personal hygiene as directed by the plan of care for 1 of 3 residents (R55) reviewed for activities of daily living (ADL). Findings include: R55's quarterly Minimum Data Set (MDS) dated 8/30/16, identified diagnoses that included dementia and heart failure. The MDS further identified R55 required extensive assistance with personal hygiene. R55's plan of care dated 6/7/16, directed staff to comb/brush hair, provide oral cares, wash glasses, apply deodorant, wash hands/face, wash underarms, and provide perineal care. R55's ADL short term care plan dated 9/7/16, identified under grooming, staff: "does everything but resident washes face." During observation on 9/20/16, at 9:22 a.m. R55 was seated in her wheelchair in her room in front of the television. Several of R55's fingernails had a dark substance underneath them. At 3:18 p.m. R55 was again observed in her room in front of	2 565	0565 - Corrected	10/18/16

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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.

When interviewed on 9/21/16, at 8:42 a.m. nursing assistant (NA)-A stated NA-B assisted R55 with personal hygiene this morning. NA-A stated staff provide the majority of cares for R55, but se can wash her hands after staff hand her the washcloth. NA-A stated if debris was noted under any resident's fingernails, he would soak them and provide nail care. At this time NA-A observed R55 in the dining room, sitting at the table, and verified there was a dark substance beneath several fingernails on both hands, and this would be taken care of.

When interviewed on 9/21/16, at 9:24 a.m. NA-C stated nail care is provided on bath days.

When interviewed on 9/21/16, at 11:38 a.m. NA-B stated she is a nursing assistant and also provides range of motion (ROM) to residents. NA-B verified she did assist R55 with personal cares this morning, and provided a washcloth for R55 to wash her own face and hands. After cares were complete, ROM was provided on her hands, but denied noticing any dark substance beneath R55's nails, and if it was noted she "probably would have cleaned them." NA-B returned at 11:50 a.m., stating R55 receives a bath on Wednesday evenings, so would be getting a bath later, when nail care would be provided. NA-B verified it would not be sanitary to eat with a brown substance beneath the fingernails.

On 9/21/16, at 12:27 p.m. R55 was observed

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2 565	Continued From page 4 sitting in a wheelchair in her room, with both hands soaking in a sudsy water filled basin. NA-A and licensed practical nurse (LPN)-A were both present in the room, and a nail file and clipper were noted on the table in front of the basin. At this time, LPN-A verified R55 had a dark substance beneath several fingernails on both hands prior to being soaked. LPN-A stated nail care is provided on bath days, but it is her expectation that staff are cleaning resident's fingernails if they are noted to be dirty. Facility policy titled Care Management dated effective 3/1/10, identified coordination of the plan of care is the responsibility of nursing: however, planning, implementation, and evaluation require joint participation by each discipline rendering service. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate nursing staff regarding implementation of a residents care plan, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	2 920		10/18/16

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2 920	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided to 1 of 3 residents (R55) reviewed for activities of daily living (ADL) whom was dependent on staff for care. Findings include: R55's quarterly Minimum Data Set (MDS) dated 8/30/16, identified diagnoses that included dementia and heart failure. The MDS further identified R55 required extensive assistance with personal hygiene. It also identified the Brief Interview for Mental Status (BIMS, as screening tool used to determine cognition) R55 to have severe cognitive impairment. R55's plan of care dated 6/7/16, directed staff to comb/brush hair, provide oral cares, wash glasses, apply deodorant, wash hands/face, wash underarms, and provide perineal care. R55's ADL short term care plan dated 9/7/16, identified under grooming, staff: "does everything but resident washes face." During observation on 9/20/16, at 9:22 a.m. R55 was seated in her wheelchair in her room in front of the television. Several of R55's fingernails had a dark substance underneath them. At 3:18 p.m. R55 was again observed in her room in front of 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. When interviewed on 9/21/16, at 8:42 a.m.	2 920	0920 - Corrected	

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2 920	Continued From page 6 nursing assistant (NA)-A stated NA-B assisted R55 with personal hygiene this morning. NA-A stated staff provide the majority of cares for R55, but se can wash her hands after staff hand her the washcloth. NA-A stated if debris was noted under any resident's fingernails, he would soak them and provide nail care. At this time NA-A observed R55 in the dining room, sitting at the table, and verified there was a dark substance beneath several fingernails on both hands, and this would be taken care of. When interviewed on 9/21/16, at 9:24 a.m. NA-C stated nail care is provided on bath days. When interviewed on 9/21/16, at 11:38 a.m. NA-B stated she is a nursing assistant and also provides range of motion (ROM) to residents. NA-B verified she did assist R55 with personal cares this morning, and provided a washcloth for R55 to wash her own face and hands. After cares were complete, ROM was provided on her hands, but denied noticing any dark substance beneath R55's nails, and if it was noted she "probably would have cleaned them." NA-B returned at 11:50 a.m., stating R55 receives a bath on Wednesday evenings, so would be getting a bath later, when nail care would be provided. NA-B verified it would not be sanitary to eat with a brown substance beneath the fingernails. On 9/21/16, at 12:27 p.m. R55 was observed sitting in a wheelchair in her room, with both hands soaking in a sudsy water filled basin. NA-A and licensed practical nurse (LPN)-A were both present in the room, and a nail file and clipper were noted on the table in front of the basin. At this time, LPN-A verified R55 had a dark substance beneath several fingernails on both hands prior to being soaked. LPN-A stated nail	2 920		

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2 920	Continued From page 7 care is provided on bath days, but it is her expectation that staff are cleaning resident's fingernails if they are noted to be dirty. Facility policy titled Activities of Daily Living (ADL) /Skills dated effective 9/14/10, identified under hygiene, resident self-image is maintained. SUGGESTED METHOD OF CORRECTION: The director of nursing could monitor for compliance with all direct care staff in providing resident assessment needed for nail care. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;	21390		10/18/16

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21390	Continued From page 8 G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop an infection control program to include the trending and analysis of collected infection data to reduce the risk of transmission to other residents in the facility. This had the potential to affect all 79 residents whom resided in the facility. Findings include; A facility Infection/Antibiotic Tracking Record dated June 2016, identified the following infections: 3 Clostridium Difficile (C-Diff) infections (infection caused by bacteria which causes inflammation of the large intestine and can cause flu-like symptoms), 8 cases of unknown respiratory infection and 6 urinary track infections (UTI). The report identified each specific resident, symptoms, treatment, isolation and where the infection acquired information. The record did not identify what room the resident resided in, the organism identified and when the infection was resolved. There was no analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to staff was deemed necessary. A facility Infection/Antibiotic Tracking Record dated July 2016, identified the following	21390	1390 - Corrected	

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21390	Continued From page 9	21390		

infections: 5 UTI's, 2 conjunctivitis (inflammation of the outermost layer of the white part of the eye and the inner surface of the eyelid), 2 pneumonia and 2 methicillin resistant staphylococcus aureus (MRSA, a bacteria resistant to several antibiotics). The record did not identify what room the resident resided in, the organism identified, or when the infection was resolved. There was no analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to staff was deemed necessary.

A facility Infection/Antibiotic Tracking Record Dated August 2016, identified the following infections, 13 UTI's, 1 conjunctivitis, and 1 staphylococcus skin infection. The record did not identify what room the resident resided in, the organism identified and when the infection was resolved. There was no analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to staff was deemed necessary.

A facility Infection/Antibiotic Tracking Record Dated September 2016, identified the following infections: 3 bronchitis, 2 UTI's, 1 pneumonia, and 1 conjunctivitis. The record did not identify what room the resident resided in, the organism identified and when the infection was resolved. There was no analysis of the collected data to determine if potentially infectious disease was spreading in the facility or if education to staff was deemed necessary.

Review of a first quarter Infection Control Report for January-March 2016, identified 33 cases of gastroenteritis (inflammation of the gastrointestinal tract which cases diarrhea, vomiting and abdominal pain). Daily tracking and

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21390	Continued From page 10 hand washing audits were completed. Review of the second quarter Infection Control Report for April-June 2016 identified there was a higher rate of respiratory infections down one particular lane and residents were isolated depending on their symptoms. There was also an increase in UTI's house wide and staff were given an infection control inservice on standard precautions, providing proper peri-care and hand hygiene. When interviewed on 9/21/16, at 11:21 a.m. director of nursing (DON) stated she was responsible for the program. The infection data collected by the facility nursing staff and the DON reviewed it on a weekly basis. The information was analyzed for trends based on the number of incidents identified for each infection, but not by the identified organism. The DON stated in the beginning of January 2016, she discussed with the medical director the importance of culturing organisms from urine cultures and monitoring trends as there had been an increase in UTI's in the facility. In June 2016, education was provided to nursing assistants on handwashing, pericare and preventing the spread of infection because she believed the increase in UTI's was a "staff education issue". In a subsequent interview on 9/21/16 at 3:35 p.m. with DON stated cultures were not currently being tracked by the facility and she needed to "reeducate the staff" on the infection control logs. Further, DON stated identifying the organism for particular infections would be beneficial so she could track any trends within the facility. A facility policy titled, "Infection Control Program" dated 3/1/2010, identified, "the primary purpose	21390		

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21390	Continued From page 11 of the facilities infection control policies and procedures is to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environments and to help prevent the development and transmission of disease and infection." SUGGESTED METHOD OF CORRECTION: The facility administrator or designee could review and revise policies and procedures in relation to the facility's infection control program. The administrator or designee could provide education to all facility staff on infection control. The administrator or designee could do weekly/monthly audits for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21390		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident living spaces were kept in good repair for 3 of 5 resident rooms (RM) including (RM-227, RM-317, and RM-326) observed to have damaged walls.	21685	1685 - Corrected	10/11/16

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21685	Continued From page 12 On 9/19/16, at 3:52 p.m. RM-227 was observed to have gouges, missing paint, and exposed sheet rock on the wall behind the resident's recliner. When interviewed on 9/21/16, at 8:58 a.m. housekeeping (HK)-B observed wall in RM-227 and stated the wall did not look good behind the resident's recliner. She stated the wall had a lot of scratches and the sheet rock was exposed from the recliner hitting the wall. HK-A added the wall was "not cleanable" due to the scratches and the exposed sheet rock and the wall needed be repaired. HK-A stated she was "not sure" if she was suppose to let maintenance know or not when she saw damaged walls. HK-A also stated she was aware that when a room was deep cleaned, either upon resident discharge or random deep cleaning room rotation, housekeeping checked the room for any needed repairs, however; if wall damage was noted during the routine course of cleaning, she was unsure of the process and she had not been reporting these concerns to the maintenance department. During interview on 9/21/16, at 11:14 a.m. director of maintenance (DM) stated there were scuff marks penetrating the first layer of paint behind the resident's recliner in RM-227. The DM stated the scuff marks measured 32" (inches) x (by) 12" and were caused by the resident's recliner hitting the wall. DM added, "It is not a cleanable surface," and he would repair the damaged wall. On 9/19/16, at 4:20 p.m. RM-317 was observed to have several areas of exposed sheet rock and missing paint on the wall behind the resident's recliner.	21685		

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21685	Continued From page 13 When interviewed on 9/21/16, at 8:52 a.m. HK-A observed wall in RM-317 and stated the damaged wall was caused by the resident's recliner hitting the wall. She further stated the wall was scraped up, sheet rock was exposed, and the wall needed to be repainted. HK-A added, "This surface is not cleanable the way it is right now." During interview on 9/21/16, at 11:21 a.m. DM stated there were multiple scuffs marks on the wall in RM-317 behind the resident's recliner that measured 20" x 7" and they needed to be repaired due to the area being a non-cleanable surface. On 9/19/16, at 6:34 p.m. RM-326 was observed to have missing paint and exposed sheet rock on the wall behind the resident's recliner. When interviewed on 9/21/16, at 8:44 a.m. HK-A observed wall in RM-326 and stated she did not like the way the wall looked and the wall needed to be repaired. She stated the wall was scrapped up, had exposed sheet rock, and needed to be repainted. HK-A further stated, "This wall is not cleanable the way it is now." HK-A added, housekeeping deep cleans one room per day, and they also deep clean resident rooms when a resident was discharged from the facility. When deep cleaning, if housekeeping staff notice any work that needed to be done in the room, they were to notify maintenance. During interview on 9/21/16, at 11:24 a.m. DM stated there were multiple scuffs on the wall in RM-326 that measured 40" x 12" and an additional area with scuff marks that measured 6" x 6". DM stated, "This is an uncleanable surface that needs to be repaired." DM also stated he would repair the damaged wall.	21685		

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21685	Continued From page 14 When interviewed on 9/21/16, at 11:09 a.m. DM stated each floor of the facility had a "work log" that was kept at the nurse's station for environmental issues to be logged. Staff were to tell the nurses of any environmental concerns and the nurses were to document the concern on the work log. He further stated he checked the work log on each floor daily for any concerns listed on the log pertaining to temperatures in the rooms, wall damage, wheelchair concerns, beds, call lights, light bulbs, or television concerns. In a subsequent interview on 9/21/16, at 11:41 DM stated it was his understanding that when housekeeping did their cleaning, housekeeping was to report any noted room damage to the maintenance department and the issue should also be written on the work log. DM further stated he did not have a checklist to check each room for damages at specific times, nor was he aware of any facility policy for maintenance to check resident rooms at specific time intervals. DM added he had a solution to the problem which was to educate staff on reporting issues, get a log report for housekeeping to fill out, and make sure a set distance for recliner placement to make sure recliner's were kept a distance away from the walls to prevent damage. A facility policy on building maintenance was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop a maintenance program to ensure damaged walls are repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring	21685		

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21685	Continued From page 15 systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	21685		