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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: UPBH

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. OTTO'S 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 **08/22/2014** (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 :
Jessica Sellner, Unit Supervisor — 08/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 10/27/2014 (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 10/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245257

August 29, 2014

Mr. Brian Bernander, Administrator Administrator
St. Otto's Care Center
920 Southeast 4th Street
Little Falls, Minnesota 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 August 8, 2014 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.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 29, 2014

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

RE: Project Number S5257024

Dear Mr. Bernander:

On July 25, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2014. 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 August 22, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 10, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 08, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 10, 2014, effective August 8, 2014 and therefore remedies outlined in our letter to you dated July 25, 2014, 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
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245257	A. Building B. Wing	8/22/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **08/04/2014**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **08/08/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **08/01/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/08/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/08/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	08/29/2014	29249	08/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/10/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UPBH

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 **07/10/2014** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Mary Rogers, HFE NE II 08/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 09/11/2014 (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 :
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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 09/18/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 25, 2014

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

RE: Project Number S5257024

Dear Mr. Bernander:

On July 10, 2014, 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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7365
Fax: (320)223-7365

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 August 19, 2014, 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 August 19, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (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 October 10, 2014 (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 January 10, 2015 (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
Division of Compliance Monitoring
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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
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
	245257	A. BUILDING _____ B. WING _____	07/10/2014

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 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.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		8/4/14

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

Electronically Signed | 07/30/2014

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.

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 _____	07/10/2014

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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy was maintained during invasive procedures, for 1 of 1 resident (R110) who was observed in a public area during a blood draw. Findings include: R110's annual Minimum Data Set (MDS) dated 6/3/14, identified the resident had a diagnosis of dementia and had severe cognitive impairment. During a random observation on 7/9/14, at 7:27 a.m. R110 was seated in her wheelchair in the day room of the facility's third floor, Pine unit, when ward clerk-A and laboratory phlebotomist- A (a service contracted through the local hospital) approached R110. Ward clerk-A stated to R110, "We're going to take a little blood test for the... doctor." Ward clerk-A sat on a chair next to R110 and rolled up one of the residents sleeves. Laboratory phlebotomist-A rested her supply carrier on the day room table, organized her supplies, donned gloves, and proceeded to draw a tube of blood from R110's arm. Relocation to a more private setting was not offered to R110. Three other residents were sitting in the day room when R110 was having blood drawn. One of the residents in the day room was seated two chairs away from ward R110 and was watching the resident during her blood draw. During interview on 7/9/14, at 7:30 a.m. ward clerk-A stated it was a common practice for resident blood draws to be completed in the facility's day room. Ward clerk- A stated, "Are you suggesting that we go to everybody's rooms to	F 164	F164-D - It is our intent to provide privacy to all residents during medical treatments and/or procedures. Director of Nursing and/or designee reviewed and update Resident Rights/ Dignity policy and procedures. Medical treatments and/or procedures will be complete in resident□s room and/or privacy curtains available. All staff will be educated on privacy during treatments and procedures by 8/4/14. RN□s will complete random audits on privacy during invasive procedures weekly X 4 weeks, then monthly. Corrective action will be complete by 8/4/2014	

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draw their blood?" Ward clerk-A stated, blood draws were typically completed wherever the resident is at the time the laboratory personnel arrived, except in the facility dining rooms.

During interview on 7/9/14, at 7:31 a.m. laboratory phlebotomist-A stated blood draws were completed either in facility day rooms or in resident rooms, depending on where the resident was at the time of her arrival.

During interview on 7/10/14, at approximately 3:00 p.m. the director of nursing (DON) stated the laboratory personnel come to the nurse's station with a list of laboratory orders that needed to be carried out and the facility staff escort the phlebotomist to where the residents are located. The DON verified it was her expectation privacy be maintained during medical procedures, including blood draws, unless the resident refused to relocate to a more private setting. The DON confirmed she would have expected a private setting at least be offered to a resident who was to have a blood draw. She added, "... most of the time it is completed in the resident's room." The facility administrator was present at the time of this interview and reiterated the DON's statements.

Review of the facility's Resident Rights/Dignity policy dated 3/1/10, instructed, "Staff are to be aware of [each] resident's right to privacy and to use appropriate equipment/approaches when caring [for] and communicating with residents... The resident room door is closed and/or curtain pulled between beds for privacy... If a room door/curtain does not ensure privacy, there are available portable privacy screen[s] on each lane to use in rooms or lounges for privacy."

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F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an assessment was completed for 3 of 4 residents (R25, R94, R100) who were observed to self administer a medication during medication pass. Findings include: R25's care plan dated 2/12/14, identified diagnoses including vascular dementia, cardiovascular accident with hemiplegia, Parkinson's Disease, cataracts, and senile psychotic condition. R25's quarterly Minimum Data Set (MDS) dated 5/7/14, indicated R25 was rarely/never understood, had short and long term memory problems, had severely impaired cognitive skills for daily decision making, had difficulty focusing, and needed extensive assistance for all activities of daily living (ADLs). During observation of medication administration on 7/7/14, at 3:15 p.m., licensed practical nurse (LPN)-C gave R25 oral medications and then poured a liquid into the chamber of a nebulizer machine. LPN-C placed the mask over R25's nose and mouth, tightened the elastic band to secure the mask, and turned the nebulizer	F 176	F176-D It is our intent to conduct self-administration of medications assessments and be reviewed by the IDT. RN to assess R100, R25, R94 for self-administration of medications and update care plan as needed by 8/1/14. All residents on nebulizer treatments will be re-assessed for self-administration by 8/8/14. All residents will be reassessed with revised procedure with their next quarterly review. DON/designee reviewed and updated policy and procedure to reflect self-administration of nebulizers. Education will be provided to all nursing staff by 8/6/14. Self-Administration of Medication assessment will be discussed and reviewed at next Quality Council meeting 8/5/14. IDT will review self-administration of medications quarterly. RN□s will complete random audits of self-administration of nebulizers will be completed weekly X 4 weeks, then monthly, results will be reported to QA. Corrective action will be completed by 8/8/14.	8/8/14

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machine on. R25 asked many questions as to where he was, what the pills were for, and then asked, "What are you putting on my head? What's that for?" LPN-C explained the medication was for his lungs and patted R25 on the shoulder and told him she'd be back shortly to take the mask off and left the room. LPN-C walked to the medication cart which was located two rooms away from R25's room. R25 was not visible from where LPN-C stood by the medication cart. LPN-C stated R25 used a mask so it was acceptable to leave him while he received his nebulizer treatment. LPN-C returned to R25's room at 3:35 p.m. and removed the mask.

During a review of R25's medical record, physician orders instructed, "Albuterol nebs 2.5 mg/3 cc nebs bid [twice daily]." There was no order allowing R25 to self administer his nebulizer/ medications.

R25's medication administration record dated 7/2014, included, "Albuterol nebs 2.5 mg/3 cc nebs BID [twice a day]. RN do self administration medication assessment//add to neb/inhaler tx: Do periodic checks if doing correctly..." There was no evidence of a self administration assessment in R25's record.

During interview on 7/7/14, at 3:25 p.m., LPN-D stated all residents receiving nebulizer treatments used a mask and, "The nurse sets them up and then monitors them [residents]...by checking on them." LPN-D verified she did not stay with the residents when they received their nebulizer treatments.

During an interview on 7/7/14, at 3:53 p.m.,

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registered nurse (RN)-B stated, "[R25] cannot self administer [medications/ nebulizer] so no assessment would be done...I think we have a form that we would fill out if they are capable [to self administer medications], but [R25] is not capable." RN-B also stated if a resident is assessed and capable of self administering medications, it would be on their care plan.

R25's care plan dated 2/12/14, lacked evidence the resident was able to safely self administer a nebulizer treatment.

During an interview on 7/10/14, at 10:40 a.m. LPN-B stated she administered medications to residents. LPN-B stated, "[R25] gets nebulizer treatments but not on my shift. He uses the mask. I don't know who determines if they're [residents] safe." LPN-B stated she did not feel R25 was safe to administer his own nebulizer and stated, "I'd say no. He is almost blind and a feeder [requires assistance with eating]. He uses a mask because he'd never be able to hold it."

R94 was admitted to the facility on 5/8/13. R94's diagnoses listed on the care plan dated 4/18/14, included malaise and fatigue, hearing loss, and chronic airway obstruction. R94's annual MDS, dated 4/16/14, indicated R94 was cognitively intact and required extensive assistant for bed mobility, transfers, dressing and toileting.

During an observation on 7/10/14, at 9:29 a.m., R94's room was closed and the resident was sitting in a chair, had a nebulizer mask on, and a nebulizer treatment was in process. LPN-D stated, "[R94] is alert and oriented and does fine," with the nebulizer treatment. LPN-D stated when a nebulizer was first ordered for a resident the

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nurses, "Do an assessment for hand held or a mask. It should be on the MAR that they have been assessed or on the care plan."

During a review of R94's record, a physician's order dated 5/27/14, included "Duo-nebs BID and q [every] 4 hrs [hours] prn [as needed]." There was no evidence of an order allowing R94 to self administer the nebulizer.

R94's medication administration record dated 7/2014, included, "Duo-Nebs bid and q 4 hrs. prn. RN DO SELF ADMIN MED ASSESSMENT//ADD TO NEB/INHALER TX: DO PERIODIC CHECKS IF DOING CORRECTLY..." There was no evidence of a self administration assessment in R94's record.

A review of R94's care plan, dated 4/18/14, identified R94 was alert and oriented and had short term memory loss at times. The care plan lacked evidence a self administration assessment had been completed or that R94 could safely self administer his nebulizer treatment.

During interview on 7/10/14, at 9:36 a.m., RN-A stated, "The lane nurse [nurse administering medication] assesses them to make sure they can do it [self administer medication]."

During interview on 7/10/14, at 9:40 a.m., Medical Records-A stated, "I honestly don't know if we do one [self administration assessment] for nebulizer's. I don't think we have anyone that sets it up themselves."

During interview on 7/10/14, at 1:50 p.m., director of nursing (DON) stated residents who received nebulizer treatments would have a self

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administration assessment completed to make sure it is safe to leave them unattended during the treatment. DON stated, "If you don't find the assessment in the chart, I don't have one."

R100 was observed in her room receiving a nebulizer treatment on 7/7/14, at 4:39 p.m. Nursing staff were not in the room and there was no nursing staff observed in the hallway close to the resident room.

R100's quarterly MDS dated 5/14/14, and indicated R100 was cognitively intact, had intermittent sleep disturbance, and was independent with ADLs other than needed extensive assistance of one staff with dressing.

The Care Area Assessment (CAA) dated 5/14/2014, identified R100 had delirium on 2/14/14, that had resolved by 2/21/14. Her cognition fluctuated depending on her day related to her anxiety and COPD (chronic obstructive pulmonary disease), and was at risk for a decline in her cognition. The CAA indicated the residents vision blurred when reading, and her cognition fluctuated day to day causing her anxiety and difficulty making decisions at times.

R100 current care plan dated 2/21/14, did not address self-administration of medication.

R100's physician orders dated 7/2/14, indicated the nebulizer machine could be kept in the resident's room at all times with one dose of Albuterol, however, there was no indication R100 was assessed as being safe to self-administer her medications/nebulizer.

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F 176	Continued From page 8 During interview on 7/10/14, at 10:45 a.m. LPN-B stated R100 always self-administered her nebulizer medication. LPN-B was unsure if R100 had a medication self administration assessment completed to determine if the resident was safe to self administer medications/ nebulizer's. During interview on 7/10/14, at 10:50 a.m. RN-A stated R100 had not been assessed to self-administered the Albuterol nebulizer safety and a medication self administration assessment should have been completed. A review of the facility's Self-Administration of Medication By Residents policy, dated 5/17/08, indicated, "The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment (Form 26), which is placed in the resident's medical record."	F 176		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		8/1/14

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F 278	Continued From page 9 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Minimum Data Set (MDS) assessment accurately reflected each resident's condition related to the presence of an unstageable pressure ulcer, for 1 of 3 residents (R18) reviewed for pressure ulcers. Findings include: R18's Diseases Index Report dated 5/17/14, identified he was admitted for rehabilitation post a hip joint replacement, and had diagnoses including Alzheimer's disease, generalized muscle weakness, and presence of a pressure ulcer to his ankle. Review of the facility's Wound Care Data Forms from 3/8/14, through 6/28/14, indicated the resident had a round, brown colored area which was "newly" identified on R18's right heel. The area measured 3.0 centimeters (cm) by 2.0 cm. Weekly monitoring of the area included the following descriptions of the wound: · 3/16/14, right heel intact hematoma,	F 278	F278-D - It is our intent to assure the MDS is coded accurately. RN has modified R18 previous MDS for accuracy and compliance. Staff education provided on 7/29/2014 for MDS accuracy. DON/designee will audit section M on MDS for accuracy 1 MDS, per floor, X 4 weeks, then 1 per floor per month X 3 month. Audit findings will be reported to Quality Council. Corrective action will be completed by 8/1/14.	

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F 278	Continued From page 10 measuring 2.5 by 2.0 cm. · 3/22/14, right heel, measuring 2.0 by 2.0 cm. · 3/29/14, 4/5/14, 4/12/14, 4/27/14, and 5/10/14, right heel measuring 2.0 by 2.0 cm. · 5/17/14, right heel, black in color, measuring 1.5 by 1.0 cm. · 5/24/14, right heel, hematoma/ scab, measuring 1.5 by 1.0 cm. · 6/1/14, 6/7/14, 6/14/14, 6/21/14, and 6/28/14, right heel, measuring 1.5 by 1.0 cm. The Wound Care Data Forms did not define the area as a pressure ulcer, nor did it identify the stage of the pressure ulcer. An orthopedics physician progress note dated 4/10/14, included a detailed evaluation of R18's feet. The evaluation noted, "[Resident] also exhibits a stable, black eschar decubitus ulceration to the posterior lateral aspect of the right calcaneal [heel] region." R18 quarterly MDS dated 5/6/14, indicated R18 had no unhealed pressure ulcers at stage one or higher. The MDS failed to identify R18's unstageable pressure ulcer. During interview on 7/10/14, at 9:45 a.m. registered nurse (RN)-A described the facility's process for completion of resident MDS assessments. RN-A explained the facility MDS nurses do not look at the residents' skin for the MDS coding but review the residents' medical record for documentation of wounds to guide their coding determinations for the skin conditions section of an MDS assessment. RN-A stated she typically reviewed a resident's record at least monthly and if a potential pressure ulcer was present, she sought physician classification/ diagnosis of the area. She stated a physician	F 278		

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F 278	Continued From page 11 diagnosis was required in order to identify a resident with a pressure ulcer on the MDS assessment. RN-A reported she did not complete R18's MDS assessments and the RN who did complete it was unavailable for interview. During interview on 7/10/14, at approximately 3:00 p.m. the director of nursing (DON) stated each resident's MDS assessment should be accurate when submitted. DON stated an area needed to be diagnosed by a physician as a pressure ulcer in order to code it as such in their MDS assessment. Upon inquiry, the DON verified the orthopedic physician's description of the area as a "decubitus ulceration" was synonymous with stating the area was a pressure ulcer.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure wheelchair positioning was re-evaluated for 1 of 1 resident (R4) who was reviewed for wheelchair positioning. Findings include:	F 309	F309-D - It is our intent to provide proper wheelchair positioning for residents. R4 was evaluated for wheelchair positioning on 7/28/14, recommendations and care plan updated as needed. DON and/or designee reviewed and updated policy and procedure. Education with nursing	8/8/14

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F 309	Continued From page 12 R4 was observed on 7/7/14, at 5:15 p.m. sitting in a wheelchair at a table in the dining room and was leaning significantly leaning to the right. She was being fed her evening meal by an unidentified nursing assistant. The resident was leaning to the right throughout the entire meal and was not provided assistance to reposition. R4's quarterly MDS dated 6/18/14, and identified the resident had severe cognitive impairment, was unable to communicate and rarely understood others, was totally dependent on staff for locomotion (wheelchair), had functional limitations to upper and lower extremities, and the resident's balance was impaired and was unable to stabilize herself. A Care Area Assessment (CAA) was completed on 1/27/14. The CAA identified the resident was not able to make own decision and rarely understood others. She continued to have behaviors and was short tempered with personal cares. R4's care plan dated 6/20/14, identified the resident had self-care deficits related to end stage dementia. She was unable to dress, groom, and bathe herself related to end stage dementia. R4's care plan did not address wheelchair positioning or referral to occupational therapy/physical therapy for wheelchair positioning issues. R4 was seen by occupational therapy (OT) for four sessions from 3/12/14, to 4/2/14, for positioning deficits as result of weakness, fatigue, and declining dementia. The staff had reported the resident was leaning to the right and forward	F 309	staff on wheelchair positioning to be completed by 8/6/14. All residents positioned in wheelchairs will be observed during walk through for proper positioning by 8/8/14. Assessment and referrals to therapy will be made for those identified with improper positioning. All residents will be reassessed with revised procedure on their next quarterly review. To sustain compliance the facility will randomly audit residents in wheelchairs during walk through for proper positioning weekly X4, then monthly. Referrals will be made to therapy for positioning evaluation as needed. Corrective action will be completed by 8/8/14.	

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in her wheelchair from time to time and were concerned about increased fall risk due to poor postural positioning. Nursing had attempted to sit the resident in a recliner during the day without adequate success. The assessment from the OT therapist identified the resident had increased leaning in her wheelchair when she was sleeping. The OT discharge summary indicated the nursing staff had been educated to lay the resident down in a recliner after breakfast, and to lie the resident down in bed after lunch. The nursing staff were also instructed to lay the resident down when the resident was seen leaning in her wheelchair.

R4 was observed on 7/7/14, at 7:10 p.m. sitting in her wheelchair in the TV/Common area on second floor and was leaning to the right.

R4 was continuously observed on 7/9/14, from 7:23 a.m. to 9:11 a.m. R4 was seated in her wheelchair in the hallway of the facility in a row of residents who were waiting for their medications. She was leaning to the right. At one point R4 was leaning to the right significantly and was leaning directly onto the wall. R4 attempted to sit upright, but continued to lean to the right. During the continuous observation no staff was observed offering the resident assistance to reposition or lay the resident down.

An interview with registered nurse (RN)-A was completed on 7/9/14 at 11:57 a.m. she reported she was not aware R4 was continuing to lean while seated in her wheelchair. Indicated the resident was seen by OT in the recent past for evaluation of her leaning forward and to the right while she sat in her wheelchair during the day. She reported they were very concerned R4 would fall out of her wheelchair due to leaning.

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	245257	A. BUILDING _____ B. WING _____	07/10/2014

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ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

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F 309	Continued From page 14 During interview on 7/9/14, at 12:04 p.m. RN-E stated she had not observed R4 leaning when she was sitting in her wheelchair. During interview on 7/9/14, at 12:14 p.m. nursing assistant (NA)-D stated she was aware R4 leaned to the right when she was in her wheelchair and had told the nurses about this. NA-D stated R4 had been evaluated by OT in the past and they recommended whenever the resident leaned while sitting in the wheelchair, staff was supposed to assist the resident to sit in the recliner or lay in bed. NA-D stated she had observed the resident, "leaning badly" this morning and she assisted the resident in her recliner about 9:00 a.m. this morning and the resident stayed in the recliner until about 11:15 a.m. R4 was observed in the dining room on 7/9/14 at 11:57 a.m. She was seated in her wheelchair at the dining table. The resident was sitting upright in her wheelchair and there was a blanket rolled up and placed under her elbow on her right side. During phone interview on 7/10/14, at 12:20 p.m. rehab director (RD) stated the resident's positioning should be evaluated on an ongoing basis, and if there was a problem with the resident leaning in her wheelchair, a physician order should be obtained and the resident should be seen for re-evaluation for wheelchair positioning. RD stated she did not believe the resident had been seen since 3/2014 regarding wheelchair positioning. RD stated she attended quarterly Medicare meetings to discuss resident concerns, and R4's positioning concerns were never discussed.	F 309		

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F 309	Continued From page 15 During interview on 7/10/14, at 2:47 p.m. the director of nursing (DON) stated she was not aware of any concerns regarding R4's wheelchair positioning, however, if staff had concerns regarding R4's positioning, the resident should be re-evaluated by OT. The facility's policy Positioning and Body Alignment dated 3/1/10, directed staff to position resident to maintain correct body alignment when seated in a wheelchair. The procedure for wheelchair positioning was to place the buttocks as far back in the wheelchair as possible, center head and shoulders over the hips, position hips, knees,and feet as close to 90-90-90 position as possible and support feet by placing them on foot plate or adaptive cushions. Devices are to be placed as described in the Resident Care plan. No positioning devises or positioning plan was found in the Resident Care plan.	F 309		
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	F 441		8/8/14

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F 441	Continued From page 16 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 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 establish an infection control program to include surveillance and investigation of infections that occurred in the facility, track symptoms which did not result in antibiotic use, maintain accurate and comprehensive records of infections, or perform antibiotic review to monitor the appropriate use of antibiotics. This had the potential to affect all 90 residents currently residing in the facility. Findings include: During review of the facility's infection control	F 441	F441-F It is our intent to maintain an infection control program. DON/Designee reviewed and updated policy and procedure. Previous 2 months of daily nursing report book reviewed to track and trend signs and symptoms of infection by 8/6/14. Results will be reported at next QA. Tracking and trending of infections or potential infections will occur monthly. The infection control manual has been updated to include revised systems and forms for tracking and trending infections.	

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F 441	Continued From page 17 program on 7/9/14, at 1:55 p.m. with the director of nursing (DON), who was identified as the infection control preventions nurse, components of a comprehensive infection control program were noted to be missing. The DON stated she tracked resident infections on two separate forms, the Monthly Infection Control Report and Infection Rate, which she filled out at the end of each month to track the amount of infections in the facility, and a form titled Resident Infection Surveillance, which was filled out when a resident was started on antibiotics. The DON stated she summarizes and reviews the infection control information at the quarterly Quality Assurance (QA) meetings. The only information which could be provided for the summary of resident infections was a untitled paper with a date of 2014 which summarized the facility infections as, "Noted one resident in isolation for MRSA, continues in precautions at this time. Noted 2 residents with c-diff, shared bathroom, resolved, now another isolated incident of c-diff noted, resolved as well." The DON stated she had no further summary or information regarding analyzing or tracking facility infections. A form titled Monthly Infection Control Report and Infection Rate dated 2014, contained the months from January through December listed on the top of the form, and down the side contained boxes labeled with the following: # (number) of residents started on antibiotics. # of cultures done this month. # of negative cultures this month. # of UTI (urinary tract infections) with indwelling catheter. # of UTI's. # of eye infections. # of upper respiratory infections.	F 441	Staff education provided to all nursing staff by 8/1/14. To sustain compliance the facility will audit the infection control manual to the daily nursing report book weekly x4, then monthly. Corrective action will be completed by 8/8/14.	

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F 441	Continued From page 18 # of lower respiratory infections. # of wound/ skin infections. # of GE (gastrointestinal) infections. # of other infections (describe). # of residents on isolations precautions. # of reoccurring. The boxes consisted of tally marks next to the infection identified by month, however, there was no resident information, room location, culture organism, antibiotic used, symptoms, or any trends of infections noted. In January 2014, the Infection Control Report and Infection Rate log identified 10 residents were started on antibiotics, 4 cultures were done that month, 4 UTI's, 1 eye infection, 1 lower respiratory infection, 4 wound/ skin infections, and a "tooth abscess." The report contained no further information regarding facility infections or if there were any trends identified. Review of the Resident Infection Surveillance Forms for January 2014, identified the following: 6 residents were being treated with antibiotics for a UTI. Only 2 of the 6 Resident Infection Forms identified the culture results, and the symptoms were listed for one resident as, "Complain of UTI." Another resident symptom was listed as, "Urinary retention," and the other 4 did not have any symptoms listed. During another interview on 7/9/14, at 1:55 p.m. DON stated when a resident is started on an antibiotic, a tracking form is started, however, resident symptoms without antibiotic treatment aren't tracked or trended in the facility. The facility policy titled Infection Control Program dated 3/1/10, indicated the primary purpose of the infection control program was to prevent the	F 441		

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F 441	Continued From page 19 transmission of infectious or communicable disease and to control healthcare acquired infections, and all staff was instructed they were responsible to report any signs and symptoms of infections related to themselves or the residents. The policy did not identify the required components which were needed in a facility infection control program.	F 441		

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	245257	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/09/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 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. 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	K 000		

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

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

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

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K 000	Continued From page 1 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 88 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		