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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XTWU

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) **11/01/2016**

6. DATE OF SURVEY **11/12/2021** (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)
12/31

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

12.Total Facility Beds **91** (L18)
13.Total Certified Beds **91** (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
	91			
(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 :
Susan Frericks, Unit Supervisor 12/07/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/07/2021 (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)
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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/18/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 7, 2021

CMS Certification Number (CCN): 245257

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

Dear Administrator:

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 November 26, 2021 the above facility is certified for:

91 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 91 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 7, 2021

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

RE: CCN: 245257
Cycle Start Date: September 23, 2021

Dear Administrator:

On October 20, 2021, we notified you a remedy was imposed. On November 12, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 26, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 19, 2021 be discontinued as of November 26, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 20, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 19, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

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(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) **11/01/2016**

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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
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___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
	91			
(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 :
Nicole Sassen, HFE - NE II 11/04/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 11/10/2021 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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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.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 20, 2021

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

RE: CCN: 245257
Cycle Start Date: September 23, 2021

Dear Administrator:

On September 23, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 19, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 19, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 19, 2021.
You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 19, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Ottos Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 19, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the

plan of correction should be directed to:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

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 23, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 _____	C 09/23/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/20/21-9/23/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/20/21-9/23/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5257025C (MN75920) H5257026C (MN75947) H5257027C (MN76933) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/29/2021

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 _____	C 09/23/2021

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	Continued From page 1 regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to	F 578		11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245257	A. BUILDING _____ B. WING _____	C 09/23/2021

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 578	Continued From page 2 provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 7 residents (R62) reviewed for advance directives had an accurate Provider Orders for Life-Sustaining Treatment (POLST). Findings include: R62's face sheet printed 9/23/21, indicated "Full Code" directive, and R62's diagnoses included malignant neoplasm of part of right bronchus or lung, severe centrilobular emphysema, and anxiety disorder. R62's admission Minimum Data Set (MDS) dated 8/31/21, indicated R62's cognition was severely impaired. R62's MDS further indicated R62's speech was clear, hearing was adequate, and R62 was usually able to understand others and usually able to make herself understood. R62's POLST signed was by the physician on 9/8/21. Section A, if patient had no pulse and was not breathing, "Attempt Resuscitation/CPR" was checked, indicating R62 wished to have cardiopulmonary resuscitation (CPR). Further, R62's POLST Section B indicated if R62 had a pulse and/or was breathing, "Selective Treatment" was checked. Selective Treatment on the POLST indicated basic, comfort-focused medical treatments aimed at treating new or reversible illness, and no intubation, advanced	F 578	F 578 Facility failed to ensure 1 of 7 residents (R62) reviewed for advance directives had an accurate Provider Orders for Life-Sustaining Treatment(POLST). Resident R62 was discharged at time of final results of survey so unable to edit POLST prior to her discharge. All residents charts were audited on 10/27/21 to ensure accurate POLST completion and any necessary changes are being discussed with resident/representative and being worked on for proper completion. All care plans were reviewed to ensure they indicated code status and that they are reviewed quarterly at each care conference. The Advance Directive/POLST policy was reviewed and modified to ensure accurate completion of POLST. Staff were reeducated on 10/21/21 and will continue until all staff are reeducated on proper completion of POLST. DON or designee will conduct audits of residents POLST□s which are to be completed at each residents care conference to ensure continued compliance with accurate completion of POLST□s. Results of audits will be brought to and	

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F 578	Continued From page 3 airway interventions or mechanical ventilation would be done. The POLST indicated R62's daughter/POA (power of attorney), provided "verbal ok" for CPR and Selective Treatment. Additionally, the POLST indicated registered nurse (RN)-B was the health care provider who prepared document and signed 9/7/21. However, the POLST had written instructions for "Attempt Resuscitation/CPR" indicating "Note: selecting this requires selecting "Full Treatment" in Section B)." During interview on 9/22/21, at 12:17 p.m. registered nurse (RN)-C stated a POLST cannot indicate full code/CPR with selective treatment or comfort care; a resident with a full code/CPR status should have "Full Treatment" indicated. RN-C further stated the POLST was completed incorrectly, she contacted the responsible party, provided additional education, and completed a corrected POLST. After looking at R62's POLST, RN-C stated, "CPR with selective treatment; I would correct this one." During interview on 9/23/21, at 4:19 p.m. the director of nursing (DON) stated Selective Treatment or Comfort Care should not have been selected with full code/CPR. The DON further stated, "I did have to recently educate one of my nurses on the need to follow the form guidelines". The DON agreed a POLST should not have indicated CPR and selective treatment stating, "it's in black and white; the form is very straight-forward". Additionally, the DON stated she expected staff reviewed the POLST quarterly with residents/family members, and made sure the POLST was accurate, completed correctly, and signed.	F 578	reviewed by the QAPI team.	

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F 578	Continued From page 4 R62's care plan printed 9/23/21, did not include R62's code status. The facility's POLST/Advance Directives policy reviewed 6/15/21, indicated, "For the POLST decision, discussion and education will be held with the primary decision maker and care planning team member/s, including the attending MD/NP, if possible." The policy further indicated if the primary decision maker could not meet in person, the decision could be reached by telephone conference with the primary decision maker and social service, nursing, or MD/NP; and the social worker or nursing staff would document the discussion. The policy did not provide guidelines on how a POLST should have been filled out.	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		11/4/21

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F 609	Continued From page 5 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure allegations of potential verbal abuse were immediately reported to the administrator and the state agency (SA) for 1 of 1 residents (R48) who alleged verbal abuse from staff. In addition, the facility failed to report a missing wedding ring to the SA for 1 of 1 residents (R26) who reported a missing wedding ring. Findings include: R48's admission Minimum Data Set (MDS) dated 8/13/21, indicated R48's did not have deficits in hearing or speech but R48's vision was moderately impaired. R48 had difficulty seeing reading material and used a magnifying glass. R48 was usually understood and usually able to understand others. R48 had no cognitive impairment. R48's Face Sheet dated 9/23/21, indicated R48's diagnoses include diabetes mellitus, coronary artery disease, anemia and malnutrition. R48's care plan dated 9/23/21, directed staff to assist with visual tasks per R48's request and to	F 609	F609 Facility failed to ensure allegations of potential verbal abuse were immediately reported to administrator and the state agency (SA) for 1 of 1 residents (R48) who alleged verbal abuse from staff. In addition, the facility failed to report a missing wedding ring to the SA for 1 of 1 residents (R26) who reported a missing wedding ring. Facility was unable to determine who she reported verbal abuse to. Report was filed for concern of verbal abuse for resident R48. Investigation was held per policy. Regarding R26 and the missing wedding ring, internal investigation was reinitiated to include searching of room, re-interviewing of family and re-notification of staff with more details of ring description. No resolution has been established at this time with no suspicion of theft. Ring continues to be missing. Staff were reeducated on 9/29/21 on the Abuse Prohibition Policy and again on 10/21/21 and will continue until all staff are reeducated.	

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F 609	Continued From page 6 follow facility abuse policy and procedure for abuse prevention. On 9/20/21, at 3:53 p.m. R48 stated approximately two weeks ago she requested assistance from an unidentified staff member to see the numbers on her television remote and on her phone. The unidentified staff member told her she was being lazy and refused to assist her. R48 reported the allegation of verbal abuse to another unidentified staff member the morning following the incident. R48's progress notes were reviewed for 8/6/21, - 9/23/21. No progress notes regarding the alleged incident were found. R48's abuse and neglect risk assessment dated 9/9/21, indicated R48 was at risk for maltreatment related to care needs, had weakness and chronic numbness. R48 relied on staff assistance. Reports made to the SA by the facility revealed no reports were made regarding allegation of verbal abuse made by R48. On 9/23/21, at 10:24 a.m. nursing assistant (NA)-A stated she frequently would assist R48 in the morning with cares. R48 was able to communicate, and NA-A was able to understand R48 without difficulty. NA-A stated R48 did not report allegations of verbal abuse from a staff member to her. If R48 did report it, NA-A had no reason to not believe her. On 9/23/21, at 11:10 a.m. licensed practical nurse (LPN)-A confirmed R48 was able to communicate her needs and LPN-A understood her without difficulty. R48 had not made false accusations	F 609	Missing Items Policy was updated and staff reeducated on this on 10/21/21 and will continue until all staff are reeducated. DON or designee will conduct audits 4 times weekly for four weeks and then quarterly ongoing to ensure compliance and continued compliance. Results of audits will be brought to and reviewed by the QAPI team.	

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F 609	Continued From page 7	F 609		

against staff in the past. LPN-A stated she was not made aware of R48's allegation of verbal abuse. If a resident reported an allegation of verbal abuse to an unlicensed staff member, she expected it would be reported to a nurse.

On 9/23/21, at 4:27 p.m. the director of nurse (DON) stated she expected allegations of abuse to be reported immediately to a nurse. The report would then be given to the DON, administrator or social worker so a report could be made to the SA, if appropriate. The DON confirmed she was not made aware of this incident by the unidentified staff member so it was not reported to the SA.

The facility Abuse Prohibition policy dated 6/3/21, indicated suspicions of abuse would be reported immediately but not later than two hours after forming the suspicion of abuse.

R26's quarterly Minimum Data Set (MDS) dated 7/6/21, indicated R26 had severe cognitive impairment and required assist of one staff for dressing, personal hygiene, and toilet use.

R26's Face Sheet printed 9/23/21, indicated R26's diagnoses included dementia with behavioral disturbance, anxiety disorder, and depression.

During an interview on 9/20/21, at 4:20 p.m. R26's son stated R26's wedding ring had been missing for approximately three months, and he had been told by the facility that he could have reported it to the police. R26's son further stated, "I do not believe it was lost and I'm really pissed off about it".

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F 609	Continued From page 8 During an interview on 9/23/21, at 3:05 p.m. the assistant administrator stated misappropriation of property occurred when property was misappropriated or stolen, and that misappropriation of property was reportable to the State Agency (SA). The assistant administrator further stated family felt R26 had misplaced the ring, so the facility thought it did not need to be reported to the SA. Additionally, the assistant administrator stated she was comfortable not having reported the missing ring to the SA, and R26's son was not angry when she spoke with him about the missing wedding ring. During an interview on 9/23/21, at 4:19 p.m. the director of nursing (DON) stated the administrator, assistant administrator, and DON jointly determine when a report to SA would have been made. Additionally, the DON stated any misappropriation of property should have been reported to the SA. The DON further stated, "In this case, I think since it was valuable, we should have reported it and then done our investigation process" and a wedding ring had meaning, and the allegation should have been reported to the SA. An Interdepartmental Communication (IC) dated 7/26/21, signed by registered nurse (RN)-B indicated R26's wedding ring was missing, and R26's daughter and RN-B looked through R26's room. The IC indicated it had been given to social services, laundry/environmental services, and the DON. The follow-up section of the IC indicated the assistant administrator spoke with R26's son on 7/27/21, and documented the conversation, "he did not feel a report was necessary. 'Mom is always hiding things - probably misplaced' not	F 609		

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F 609	Continued From page 9 concerned". Further documentation on the IC by the AA, "educated staff to offer report immediately if suspect stolen, family does not suspect stolen". No other documentation related to the investigation or reporting of this allegation was provided by the facility. The facility Abuse Prohibition policy dated 6/3/21, indicated a 9/10 clarification of the CMS definition of Misappropriation of Resident Property, "If a missing item potential for being a theft a VA report is to be made". The policy further indicated the facility would report to the SA not later than 24 hours if the events that caused the suspicion did not include abuse and did not result in serious bodily injury. The facility Missing Item policy dated 7/5/21, indicated missing items would be investigated promptly, and if exploitation was suspected the facility would follow the Vulnerable Adult reporting process and reporting a crime process.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		11/4/21

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F 610	Continued From page 10 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure accusations of potential abuse were thoroughly investigated for 1 of 1 residents (R48) who reported allegation of verbal abuse by a staff member. In addition, the faciliyt failed to investigate a report of a missing wedding ring for 1 of 1 residents (R26) reviewed for misappropriation of property. Findings include: R48's admission Minimum Data Set (MDS) dated 8/13/21, indicated R48 did not have deficits in hearing or speech but R48's vision was moderately impaired. R48 had difficulty seeing reading material and used a magnifying glass. R48 was usually understood and usually able to understand others. R48 had no cognitive impairment. R48's Face Sheet dated 9/23/21, indicated R48's diagnoses include diabetes mellitus, coronary artery disease, anemia and malnutrition. R48's care plan dated 9/23/21, directed staff to assist with visual tasks per R48's request and to follow facility abuse policy and procedure for abuse prevention. On 9/20/21, at 3:53 p.m. R48 stated approximately two weeks ago she requested	F 610	F610 Facility failed to ensure accusations of potential abuse were thoroughly investigated for 1 of 1 residents (R48) who reported allegations of verbal abuse by a staff member. In addition, the facility failed to investigate a report of a missing wedding ring for 1 of 1 residents (R26) reviewed for misappropriation of property. Report was filed for concern of verbal abuse for resident R48. Investigation was held per policy. Regarding R26 and the missing wedding ring, internal investigation was reinitiated to include searching of room, re-interviewing of family and re-notification of staff with more details of ring description. No resolution has been established at this time with no suspicion of theft. Ring continues to be missing. Staff were reeducated on 9/29/21 on the Abuse Prohibition Policy and again on 10/21/21 and will continue until all staff are reeducated. Missing Items Policy was updated and staff reeducated on this on 10/21/21 and will continue until all staff are reeducated. DON or designee will conduct audits 4 times weekly for four weeks and then quarterly ongoing to ensure compliance and continued compliance. Results of audits will be brought to and	

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F 610	Continued From page 11 assistance from an unidentified staff member to see the numbers on her television remote and on her phone. The unidentified staff member told her she was being lazy and refused to assist her. R48 reported the allegation of verbal abuse to another unidentified staff member the morning following the incident. R48's progress notes were reviewed for 8/6/21, - 9/23/21. No progress notes regarding the alleged incident were found. R48's abuse and neglect risk assessment dated 9/9/21, indicated R48 was at risk for maltreatment related to care needs, has weakness and chronic numbness. R48 relies on staff assistance. On 9/23/21, at 4:27 p.m. the director of nursing (DON) and administrator stated they expected allegations of abuse were investigated and action taken to prevent the potential of it happening again. Both the DON and administrator confirmed they were not made aware of the incident so it was not investigated. R26's quarterly Minimum Data Set (MDS) dated 7/6/21, indicated R26 had severe cognitive impairment and required assist of one staff for dressing, personal hygiene, and toilet use. R26's Face Sheet printed 9/23/21, indicated R26's diagnoses included dementia with behavioral disturbance, anxiety disorder, and depression. During an interview on 9/20/21, at 4:20 p.m. R26's son stated R26's wedding ring had been	F 610	reviewed by the QAPI team.	

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F 610	Continued From page 12	F 610		

missing for approximately three months, and he had been told by the facility that he could have reported it to the police. R26's son further stated, "I do not believe it was lost and I'm really pissed off about it".

During an interview on 9/23/21, at 1:14 p.m. RN-D stated she was made aware R26's wedding ring was missing from a copy of the INterdepartmental Communication (IC) posted in the nurse office.

During an interview on 9/23/21, at 3:05 p.m. the assistant administrator stated the investigation included the documented conversation with R26's son and education was provided to RN-B. The assistant administrator further stated interviews with staff and/or other residents were not conducted.

During an interview on 9/23/21, at 4:19 p.m. the director of nursing (DON) stated the allegation was not investigated, staff/family searched R26's room right away, felt maybe it fell off, and facility continued to look for it. Further, the DON stated the facility should have questioned other residents and staff. Additionally, the DON stated the facility could not have determined the wedding ring was not stolen, because an investigation had not been done.

An IC dated 7/26/21, signed by registered nurse (RN)-B indicated R26's wedding ring was missing, and R26's daughter and RN-B looked through R26's room. The IC indicated it had been given to social services, laundry/environmental services, and the DON. The follow-up section of the IC indicated the assistant administrator spoke with R26's son on 7/27/21, and documented the

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F 610	Continued From page 13 conversation, "he did not feel a report was necessary. 'mom is always hiding things - probably misplaced' not concerned". Further documentation on the IC by the AA, "educated staff to offer report immediately if suspect stolen, family does not suspect stolen". No other documentation related to the investigation of this allegation was provided by the facility. The facility Abuse Prohibition policy dated 6/3/21, indicated the facility would "follow the written policies and procedures to prohibit and prevent abuse, neglect, exploitation of residents, and misappropriation of resident property" and "establish policies and procedures to investigate any such allegations". Additionally, the policy indicated once the initial report to the SA was made, a full investigative report would be provided to the SA within five working days of the incident. The policy further indicated the investigation would be initiated by the RN supervisor on duty/designee, and the DON/Social Worker (SW) completed the SA investigative report. The facility Missing Item policy dated 7/5/21, indicated missing items would be investigated promptly, and if exploitation was suspected the facility would follow the Vulnerable Adult reporting process and reporting a crime process.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		11/4/21

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F 684	Continued From page 14 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly assess and follow up after a reported fall for 1 of 1 residents (R45) reviewed for accidents. Findings include: R45's quarterly Minimum Data Set dated 8/4/21, indicated R45's speech was clear, vision was adequate and was usually able to make himself understood. R45's cognition was moderately impaired. R45 required supervision for transfers and walking in his room. R45's balance was not steady, but he was able to stabilize himself when standing without physical assistance from staff. R45's Face Sheet dated 9/23/21, indicated R45's diagnoses included dementia, seizure disorder, and traumatic brain injury. R45's care plan edited 9/7/21, instructed staff to provide frequent reminders for R45, observe for impulsive behaviors and keep items within resident's reach when in his room. R45's care plan failed to identify the fall R45 stated he reported to staff, or interventions put in place following that fall. R45's progress note dated 8/10/21, noted a bruise on R45's left knee. R45 indicated he got the bruise when he fell, but no fall had been	F 684	F684 Facility failed to thoroughly assess and follow up after a reported fall for 1 of 1 residents (R45) reviewed for accidents. R45 had an incident report completed for the reported incident. Resident has fall interventions in place and reported fall was followed up on as able. Fall Prevention Policy was reviewed and updated. Staff were reeducated on 10/21/21 on Fall Prevention Policy and the need to report and complete incident reports/followup on all reported falls, staff education will continue until all staff are reeducated. DON or designee will conduct audits of progress notes weekly for one month and then twice a month for two months or until compliance is noted and no missed documentation of a fall without incident report, assessment and followup completed. Results of audits will be brought to and reviewed by the QAPI team.	

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	245257	A. BUILDING _____ B. WING _____	C 09/23/2021

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F 684	Continued From page 15	F 684		

reported. R45 stated he got up by himself, after the fall. "States he fell by his bed but unable to say when or what time of day."

Facility fall assessments for 2021, were requested but were not received.

On 9/20/21, at 3:38 p.m. R45 reported he fell about a month ago. R45 stated he got off the floor by himself, then told a staff member who was in the hallway.

On 9/23/21, at 10:48 a.m. nursing assistant (NA)-B stated she had not heard of R45 falling recently. NA-B also stated R45 had not previously made false statements to staff or others about falling.

On 9/23/21, at 11:13 a.m. licensed practical nurse (LPN)-A indicated an unwitnessed fall or fall reported by a resident was still considered a fall. The nurse would still need to go through the process of a skin check, vital signs, notifying a registered nurse, completing a fall incident report, and doing the post fall huddle. LPN-A stated she would have believed R45 if he told her he fell and got off the floor by himself.

On 9/23/21, at 4:27 p.m. the director of nursing (DON) confirmed an unwitnessed fall or fall reported by a resident was still considered a fall. She expected staff to follow the facility procedure for falls which included completing a fall report, documenting in progress notes, completing a skin check and monitoring for injury. Interventions to prevent future falls should be updated as appropriate. The DON stated there were no incident reports regarding a fall for R45 for the year 2021. The DON stated it was important to

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F 684	Continued From page 16 follow the facility procedures regarding falls to prevent future falls and to be able to track for possible patterns. The facility Fall Prevention policy revised 3/20/19, directed to complete the following post fall: routine vital signs, blood sugar check one time immediately after the fall, and incident report.	F 684		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental	F 791		11/4/21

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F 791	Continued From page 17 services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure dental services were provided for 1 of 2 residents (R58) reviewed for routine and emergency dental services. Findings include: R58's quarterly Minimum Data Set (MDS) dated 8/27/21, indicated R58's hearing was adequate, and speech was clear; R58 was usually able to make himself understood and was usually able to understand others. R58's cognition was moderately impaired. R58 did not have difficulty chewing or swallowing food. R58's Face Sheet dated 9/23/21, indicated R58's diagnoses included acute respiratory failure, diabetes mellitus, heart disease and hypertensive chronic kidney disease. R58's care plan dated 2/23/21, failed to address R58's dental care needs.	F 791	F791 Facility failed to ensure dental services were provided for 1 of 2 residents (R58) reviewed for routine and emergency dental services . R58 was offered a dental appointment and appointment was set up for earliest possible date. New oral assessment was completed for R58 to include broken tooth. Care plan for R58 was edited to include need for dental services due to broken tooth. Staff were reeducated on the Dental Care and Services Policy on 10/21/21 and will continue until all staff have been educated. Staff were reeducated on the process for doing the Oral Cavity Observation on 10/21/21 and will continue until all staff have been educated that the residents oral cavity must be viewed when completing assessment. DON or designee will conduct audits of	

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F 791	Continued From page 18 R58's Care Conference Notes reviewed for 7/13/21, and 9/15/21, failed to address R58's dental status and did not note if dental services were offered. R58's Oral Cavity Observation dated 8/26/21, had a question about the condition of teeth which included option for, "obvious or likely cavity or broken natural teeth." Option chosen was, "None of the above were present." On 9/20/21, at 1:27 p.m. R58 stated he had not been offered to see a dentist since admitting to the facility on 2/17/21. R58 indicated he had a "rotted out," tooth that needed to be fixed on the right side of his upper jaw. R58 stated he had not told anyone about the tooth, and no one had asked about his teeth since admission. R58 pulled his cheek back and pointed to the tooth he was concerned with. R58's tooth was observed to broken and black in color. R58 denied oral pain or discomfort and denied difficulty chewing his food. On 9/23/21, at 9:06 a.m. R58 was observed drinking a cup of coffee. R58 offered no complaints of pain or discomfort. R58 stated no one had looked in his mouth since admission. If he had been offered to see a dentist, he would have accepted. Althought R58 stated no one had looked in his mouth, someone had, but did not note the condition of R58's tooth. On 9/23/21, at 4:27 p.m. the director of nursing (DON) indicated she expected oral assessments to be completed by visual inspection. Teeth problems should be indicated on the assessment. If a resident had a likely cavity or decay, even if it wasn't causing the resident pain, discomfort or difficulty with chewing, the resident should still be	F 791	quarterly care conferences to ensure dental services is offered at each care conference. Results of audits will be brought to and reviewed by the QAPI team.	

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F 791	Continued From page 19 offered to see a dentist. The risk for the resident included pain, discomfort, lack of sleep, emesis, infection and possibly death caused by possible infection. The facility Dental Care and Services policy revised 1/2021, indicated all residents are assessed on admission and annually for dental services needs. Residents would be asked if they wished to see a dentist at each care conference.	F 791		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		11/4/21

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F 880	Continued From page 20 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure proper eye protection was worn during direct cares and medication administration. This had the potential to effect six residents (R20, R70, R57, R56, R67, R25) who received medications or personal cares during observation of medication administration. Findings include: R20's quarterly Minimum Data Set (MDS) dated 6/29/21, indicated R20's diagnoses included heart failure, hypertension, diabetes mellitus and dementia. R70's quarterly MDS dated 9/3/21, indicated R70's diagnoses included heart failure, hypertension, renal failure, and diabetes mellitus. R57's quarterly MDS dated 8/23/21, indicated R57's diagnoses included hypertension, renal failure, and diabetes mellitus. R56's annual MDS dated 8/20/21, indicated R56's diagnoses included cancer, atrial fibrillation, heart failure, and hypertension. R67's admission MDS dated 9/3/21, indicated R67's diagnoses included hypertension and peripheral vascular disease (a progressive circulation disorder). R25's admission MDS dated 7/8/21, indicated R25's diagnoses included anemia, atrial fibrillation, heart failure, and hypertension. On 9/22/21, at 7:16 a.m. licensed practical nurse	F 880	F880 Facility failed to ensure proper eye protection was worn during direct cares and medication administration. All residents are monitored at least daily and tested as needed who have symptoms or are exposed to potential infectious individuals. Root Cause Analysis was completed with IP on 10/26/21 with a corrective action plan to prevent recurrence. Policy and procedure on donning and doffing PPE during COVID with current guidelines to include crisis standard of care, contingency standard of care and standard of care was reviewed on 10/27/21. Policy and procedure including source control masks was reviewed on 10/27/21. Policy and procedure for proper use of gowns was reviewed on 10/27/21. Reviewed policy regarding standard and transmission based precautions and revised as needed on 10/27/21. Training was provided on 10/21/21 and will continue until all staff have received education on standard infection control practices, including transmission based precautions, appropriate PPE use and donning and doffing of PPE , including a competency testing of staff on donning and doffing. Residents and their representatives will receive education upon admission on Infection Prevention as it relates to them and current residents will have Infection Prevention information provide to them at their next care conference.	

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F 880	Continued From page 22 (LPN)-B was observed not wearing eye protection (goggles) when standing at the medication cart. Goggles were observed on LPN-B's medication cart at this time. LPN-B approached R20 to administer medications. LPN-B was standing within two feet of R20. LPN-B then returned to the medication cart to prepare R70's medications. LPN-B removed her eyeglasses, then entered R70's room and stood within two feet of R70 to administer medications. LPN-B then transferred her eyeglasses and goggles to a different medication cart. R57 was requesting help. LPN-B approached R57, stood within one foot of R57 while assisting him to drink water through a stray. LPN-B returned to the medication cart, prepared medications for R56, then donned goggles before entering R56's room to administer medications. Upon returning to the medication cart, LPN-B doffed her goggles and placed them on the medication cart. LPN-B entered R67's room, without wearing goggles, to assist with R67's shoes and to the bathroom with a mechanical lift. LPN-B then entered R25's room, stood within two feet of R25 to ask if she needed pain medication. Upon return to the medication cart, LPN-B donned her goggles. On 9/22/21, at 7:54 a.m. LPN-B confirmed she was in and out of several resident rooms to administer medications and assist with personal cares, without wearing goggles. LPN-B stated she was aware she was supposed to wear goggles when in close contact with all residents such as during cares and medication administration. LPN-B indicated she was not aware of the reason for the goggles or the importance of wearing them to protect herself and the residents.	F 880	DON or designee will conduct audits of donning and doffing PPE with Transmission Based Precautions i.e. Droplet precautions that are being done routinely on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits will continue until 100% compliance is met on source control masking for staff, visitors, and residents. Real time audits will be done by DON or designee on all aerosolized generating procedures to ensure PPE is on. Real time audits will be done by DON or designee on proper use of gowns to ensure PPE is in use. Results of audits will be brought to and reviewed by the QAPI team.	

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F 880	Continued From page 23 On 9/23/21, at 10:36 a.m. registered nurse (RN)-A confirmed the facility possessed enough personal protective equipment for all staff to wear goggles. RN-A expected goggles to be worn when providing direct care to residents, anything within six feet for care of residents. On 9/23/21, at 4:27 p.m. the director of nursing (DON) stated she expected all staff to wear goggles when coming within six feet of a resident such as when doing cares and medication administration. The DON stated, "We are in a time when infection is all around us. We need to protect ourselves and the residents." The DON indicated goggles were importance because of the risk of infection, hospitalization and possibly death. A copy of the facility's eye protection policy was requested but was not provided.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 20, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: XTWU11

Dear Administrator:

The above facility was surveyed on September 20, 2021 through September 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 immediately contact:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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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: On 9/20/21-9/23/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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	00817	A. BUILDING: _____ B. WING _____	C 09/23/2021

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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) COMPLETE DATE
2 000	Continued From page 1 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 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		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure dental services were provided for 1 of 2 residents (R58) reviewed for routine and emergency dental services. Findings include: R58's quarterly Minimum Data Set (MDS) dated 8/27/21, indicated R58's hearing was adequate, and speech was clear; R58 was usually able to make himself understood and was usually able to understand others. R58's cognition was moderately impaired. R58 did not have difficulty chewing or swallowing food. R58's Face Sheet dated 9/23/21, indicated R58's diagnoses included acute respiratory failure,	21325	Corrected	11/4/21

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21325	Continued From page 3	21325		

diabetes mellitus, heart disease and hypertensive chronic kidney disease.

R58's care plan dated 2/23/21, failed to address R58's dental care needs.

R58's Care Conference Notes reviewed for 7/13/21, and 9/15/21, failed to address R58's dental status and did not note if dental services were offered.

R58's Oral Cavity Observation dated 8/26/21, had a question about the condition of teeth which included option for, "obvious or likely cavity or broken natural teeth." Option chosen was, "None of the above were present."

On 9/20/21, at 1:27 p.m. R58 stated he had not been offered to see a dentist since admitting to the facility on 2/17/21. R58 indicated he had a "rotted out," tooth that needed to be fixed on the right side of his upper jaw. R58 stated he had not told anyone about the tooth, and no one had asked about his teeth since admission. R58 pulled his cheek back and pointed to the tooth he was concerned with. R58's tooth was observed to broken and black in color. R58 denied oral pain or discomfort and denied difficulty chewing his food.

On 9/23/21, at 9:06 a.m. R58 was observed drinking a cup of coffee. R58 offered no complaints of pain or discomfort. R58 stated no one had looked in his mouth since admission. If he had been offered to see a dentist, he would have accepted. Althought R58 stated no one had looked in his mouth, someone had, but did not note the condition of R58's tooth.

On 9/23/21, at 4:27 p.m. the director of nursing (DON) indicated she expected oral assessments

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21325	Continued From page 4	21325		

to be completed by visual inspection. Teeth problems should be indicated on the assessment. If a resident had a likely cavity or decay, even if it wasn't causing the resident pain, discomfort or difficulty with chewing, the resident should still be offered to see a dentist. The risk for the resident included pain, discomfort, lack of sleep, emesis, infection and possibly death caused by possible infection.

The facility Dental Care and Services policy revised 1/2021, indicated all residents are assessed on admission and annually for dental services needs. Residents would be asked if they wished to see a dentist at each care conference.

SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could audit all current residents to ensure dental service needs are being met. They could then in-service staff to ensure resident dental needs are being communicated to the appropriate person and dental needs are followed up on then audit oral care to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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	245257	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2021**

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

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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 not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/29/2021

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

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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.	K 000		

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K 000	Continued From page 2 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 91 and had a census of 75 at the time of the survey. The requirements at 42 CFR Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.	K 293		10/29/21

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K 293	Continued From page 3 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to maintain 2 of several illuminated exit signs in accordance with NFPA 101 "Life Safety Code" 2012 edition, sections 7.10.5.2 and 19.2.10. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 09/21/2021 at 11:03 AM, observations revealed that the illuminated exit sign located in the 3rd floor dining room was inoperative and was not illuminated at the time of the inspection. 2. On 09/21/2021 at 11:45 AM, observations revealed that the illuminated exit sign located in the 2nd floor dining room was inoperative and was not illuminated at the time of the inspection. These deficient conditions were verified by a Maintenance Supervisor.	K 293	K293 Exit Signage CFR(s); NFPA 101 It is our intent to be in compliance by replacing illuminating bulbs on identified exit signs in second and third floor dining rooms. All required illuminating exit signs will be visually inspected for operation and will be inspected on a routine preventative maintenance plan.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345		10/29/21

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K 345	Continued From page 4 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm in accordance with NFPA 101 "Life Safety Code" 2012 edition, section 9.6.1.3, and NFPA 72 "National Fire Alarm and Signaling Code" 2010 edition, sections 14.5.3. and 14.6.2.4. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/21/2021 at 9:45 AM, during a review of all available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. This deficient condition was verified by a Maintenance Supervisor.	K 345	K345 Fire Alarm System Testing and Maintenance CFR(s): NFPA 101 It is our intent to be in compliance with fire alarm testing and maintenance requirements. Inspection of all initiating devices have been completed and inspection and documentation will occur semi-annually.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in	K 351		10/29/21

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K 351	Continued From page 5 accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to install and maintain the fire sprinkler system in accordance with NFPA 101 "Life Safety Code" 2012 edition, section 9.7.1.1, and NFPA 13 "Standard for the Installation of Sprinkler Systems" 2010 edition, Section 6.2.9.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/21/2021 at 1:00 PM, observation revealed that there are 6 spare sprinkler heads that are not secured and protected from damage within the fire sprinkler spare head box located at the main sprinkler riser. This deficient condition was verified by a Maintenance Supervisor.	K 351	K351 Sprinkler System □ Installation CFR(s): NFPA 101 It is our intent to be in compliance with sprinkler system installation requirements. A new sprinkler head storage box was obtained and installed to store and protect the 6 freely stored sprinkler heads from damage.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		10/29/21

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K 923	Continued From page 6 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923		

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K 923	Continued From page 7 Based on observations and staff interview, it was reveled that oxygen cylinders are not being stored in accordance with NFPA 99 "Health Care Facilities Code" 2012 edition, sections 11.6.5.2 and 11.6.5.3. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 09/21/2021 at 10:47 AM, during the facility tour observations revealed in the oxygen storage room located on the 3rd floor had oxygen cylinders that were not separated by full and empty at the time of the inspection. 2. On 09/21/2021 at 11:30 AM, during the facility tour observations revealed in the oxygen storage room located on the 2nd floor had oxygen cylinders that were not separated by full and empty at the time of the inspection. These deficient conditions were verified by a Maintenance Supervisor.	K 923	K923 Gas Equipment □ Cylinder and Container Storage CFR(s): NFPA 101 It is our intent to be in compliance with gas equipment storage. Current storage area was organized with full and empty oxygen cylinders separated from each other with visible signs indicating the storage area for full (New) cylinders and for empty (Used) cylinders.	