DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 10, 2020

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

RE: CCN: 245257
Cycle Start Date: September 17, 2020

Dear Administrator:

On October 5, 2020, we notified you a remedy was imposed. On October 27, 2020 the Minnesota Department(s) of Health 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 October 15, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 20, 2020 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 5, 2020, 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 September 17, 2020. 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically Submitted
October 5, 2020

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

RE: CCN: 245257
Cycle Start Date: September 17, 2020

Dear Administrator:

On September 17, 2020, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On September 16, 2020, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of E.

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 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 October 20, 2020.

This Department is also recommending that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 20, 2020 (42 CFR 488.417 (a). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 20, 2020 (42 CFR 488.417 (a).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Ottos Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 17, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

correction (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), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 17, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 10, 2020

Shirley Brekken, Executive Director
Board of Nursing
Park Plaza Building
2829 University Avenue Southeast, Suite 500
Minneapolis, Minnesota 55414

Dear Ms. Brekken:

This is relative to a full survey conducted at St Ottos Care Center, 920 Southeast 4th Street, Little Falls, MN, 56345 and completed on September 17, 2020.

At the time of this survey it was determined that the residents in this facility have received substandard quality of care.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The director of nursing at the time of the survey was Sheila Blue.

If you have any questions on this matter, please do not hesitate to call me.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 10, 2020

Randy Snyder, Executive Director
Board of Nursing Home Administrators
Park Plaza Building
2829 University Avenue Southeast, Suite 440
Minneapolis, Minnesota 55414

Dear Mr. Snyder:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the Board of Nursing Home Administrators whenever we determine that substandard quality of care has been provided to residents. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life, § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection Control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of St Ottos Care Center, 920 Southeast 4th Street, Little Falls, MN, 56345, which was completed on September 17, 2020, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

F - 600 - Free From Abuse And Neglect

Freedom from Abuse, Neglect, and Exploitation (§ 483.12). Regulations in this area grant residents the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The administrator is Mr. Brian Bernander, Administrator.

If you have any questions, please feel free to contact me.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 10, 2020

Dr. Peter Germscheid
811 2nd St. SE
Little Falls, MN 56345

Dear Dr. Germscheid:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of St Ottos Care Center, 920 Southeast 4th Street, Little Falls, MN, 56345, which was completed on September 17, 2020, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

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The above facility has prepared a plan to correct the deficiencies which we found during the survey. You can assist by discussing the survey findings with the facility's medical director. Copies of the survey findings which provide detailed information on the violations can be reviewed at the facility.

If you have any questions, please feel free to contact me.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@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 09/17/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/14/20, through 9/17/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5257015C at F600 with an addition deficiency identified at F609. The survey resulted in an Immediate Jeopardy (IJ) to resident health and safety at F600 when R1 reported to staff on 9/4/20, that nursing assistant (NA)-A was rough with him and twisted his arm. The allegation of physical abuse was not reported until 9/5/20, when staff identified a significant bruise(s) to R1's right arm which measured 6.5 centimeters (cm) x 7 cm and 2 cm x 1 cm. The bruise on the left forearm measured 2 cm x 1 cm. Because the allegation was not reported to administration on 9/4/20, NA-A continued to work the entire shift on 9/4/20, and immediate protection from further abuse was not provided to R1 and the residents who resided on the second floor. The IJ which began on 9/4/20, was removed on 9/16/20. Further, the above findings resulted in substandard quality of care, and an extended survey was conducted on 9/17/20. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/12/2020

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
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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize their abuse prohibition policy to report and protect a resident immediately following an allegation of staff to resident abuse for 1 of 3 residents (R1) reviewed for staff to resident abuse allegations. This resulted in an immediate jeopardy situation (IJ) and had the potential to affect all 37 residents who resided on the second floor at the time of the incident.	F 600	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance.	10/15/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 2 The IJ began on 9/4/20, when R1 reported to licensed nursing staff that nursing assistant (NA)-A was rough with him and twisted his arm. The allegation of physical abuse was not reported until 9/5/20, when staff identified a significant bruise(s) to R1's right arm which measured 6.5 centimeters (cm) x 7 cm and 2 cm x 1 cm. The bruise on the left forearm measured 2 cm x 1 cm. NA-A continued to work the entire shift on 9/4/20, and immediate protection from further abuse was not provided to R1 nor the other residents who resided on the second floor, because the allegation was not reported to administration on 9/4/20. The administrator, director of nursing (DON) and licensed social worker (LSW) were notified of the IJ on 9/15/20, at 2:02 p.m. The IJ was removed on 9/16/20, at 8:33 a.m. when the facility successfully implemented a removal plan; however, non-compliance remained at a pattern scope with potential for more than minimal harm which is not immediate jeopardy (Level E). Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/17/20, identified R1 was cognitively intact and usually made themselves understood; however, had some difficulty communicating some words or finish thoughts but was able to, when prompted. The MDS did not identify any behaviors including rejection of care. The MDS further identified that R1 required extensive assistance from staff to complete toileting, transferring and bed mobility tasks. A diagnosis of dementia was identified. R1's care plan revised 7/28/20, identified R1 was at risk for "maltreatment" related to confusion from dementia, an intervention identified the	F 600	F600 Free from Abuse and Neglect CFR(s): 483.12(a)(1) It is our intent to keep residents free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. SOCC has updated and implemented policies and procedures that prohibit and prevent abuse, neglect and exploitation of residents and misappropriation of resident property along with establishing policies and procedures to report and investigate any such allegations. SOCC team members and volunteers are instructed to immediately report all witnessed and suspected incidents of abuse, neglect or misappropriation of resident property to a supervisor, Director of Nursing, Administrator/Designee. If abuse is alleged, immediate but no later than two hours reporting to the Nursing Home Incident Reporting Website is to occur. Interventions to keep alleged victim safe from further harm will be appropriately taken by facility team members/supervisors. A. (NA)-A was suspended and subsequently terminated on 9/10/20. B. R1 was interviewed and stated he felt safe at St. Otto□s Care Center. A weekly vulnerable adult assessment will be complete for 4 weeks with resident, then quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST OTTOS CARE CENTER	**920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345**

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F 600	Continued From page 3 facility would follow their abuse policy and procedures and there was known history of maltreatment or exploitation for R1. On 9/14/20, at 2:36 p.m. R1 was observed seated in his recliner with his feet elevated and had on a long sleeved shirt. R1 stated NA-A had "purposely" given him bruises on his arms when he refused to take a bath. R1 pulled up his right sleeve and there was a significant bruise to his right forearm about the size of a baseball with three smaller bruises protruding from the larger bruise, this bruise was purple/ maroon in color. R1 then pulled up his left sleeve and identified a small thumb print sized bruise to his left forearm, the bruise was also purple/ maroon in color; however, was more faded than the larger bruise on the right. R1 stated the incident took place in the bathroom. R1 further stated NA-A had a "bunch of gowns in a ball" and "threw them at his chest," and NA-A told R1 to put the gown on and told him he was going to take a bath. R1 told NA-A he was not going to take a bath because he was not feeling well that evening and had the chills. R1 went on to state that NA-A kept arguing with R1 about putting the gown on. NA-A was grabbing and holding onto R1's arms. At one point NA-A placed something around his arms. NA-A grabbed his arms again and was holding R1's arms. R1 told NA-A "keep your goddamn hands off of me." NA-A was very "mean like and rough." NA-A then pulled his right arm away and twisted it, trying to make him put on the gown. R1 demonstrated with his hands a twisting motion with his hands moving in an opposite direction creating a friction motion. R1 stated NA-A then grabbed both of R1's arms and pushed them towards R1's chest knocking him from a standing position back onto the toilet to a seated position.	F 600	C. St. Otto□s Care Center interviewed all residents on 9/15/20 who could have had an adverse outcome as a result of the non-compliance. Residents that were unable to answer questions verbally had skin assessment completed as they awoke and got ready for the day on 9/16/2020. D. Vulnerable adult education and mandated reporting requirements was provided on 9/15/20 to all team members. Vulnerable adult/mandated reporter education will occur upon hire, annually and in department meetings throughout the year. Education also provided included Abuse Prevention in Persons with Dementia via online training module. E. The Resident Vulnerable Adult Assessment that is completed upon admission and annually was changed to be completed upon admission and quarterly thereafter. F. Audits that include simulated scenarios will be conducted by the DON/designee for 3 months and on a random basis to ensure immediate reporting is completed based on the simulated scenarios. Findings will be reported to the QAPI committee	

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R1 stated what NA-A did hurt him, and was acting like "Hitler." NA-A then threw the gown or robe into the bathroom corner and left the room. R1 stated other staff were aware the evening of the incident because someone came in to assist him and there was a lot of yelling going on. Further, R1 told the staff that came to his room NA-A grabbed and twisted his arm. R1 stated that was the first time NA-A had ever become physical with him and had no concerns with other staff. He had not seen NA-A since that evening.

An untitled incident report was submitted to the state agency (SA) on 9/5/20, at 8:41 p.m. by the facility administrator. The incident report identified an allegation of physical abuse resulting in a bruise of unknown origin. The date and time of the incident was identified on 9/4/20, at 9:00 p.m. The description of the incident was identified as "Bruise on right forearm identified during weekly skin assessment of resident by LPN [licensed practical nurse]. Resident states his arm was grabbed by a CNA [nursing assistant] the previous evening while in the restroom prior to bed. Alleged perpetrator is not in facility or on the schedule until afternoon of 9/8/2020. Resident in normal mindset and mood. Not worried about safety at this time. Further investigation to be completed."

The untitled completed investigation was submitted to the SA on 9/10/20, at 3:34 p.m. and identified NA-A was suspended during the investigation and subsequently terminated for causing bruising to R1's arms. The facility investigation concluded based on interviews with staff, R1 and NA-A an "altercation" did occur on 9/4/20, on the evening shift in R1's bathroom. R1 had clearly identified NA-A by name with

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interviewers and other staff. R1's story remained consistent. R1 had bruising to his bilateral arms. NA-A confessed to an altercation with resident on 9/4/20, and identified they "probably gave the resident three of the four bruises while trying to assist with putting on a gown for bed." NA-A stated they were trying to calm R1 down. NA-A stated should not have grabbed R1's arms and raise voice. Several employees and residents were interviewed as part of the investigation.

The undated untitled internal staff interviews form included the following staff interviews:

-9/8/20, at 1:16 p.m. trained medication assistant (TMA)- A reported R1 had a rough night on 9/4/20. NA-A came and got LPN-A for help because R1 would not get off the toilet. TMA-A and LPN-A went in R1's room to assist. When entering the room R1 was "agitated" and did not want his gown on. TMA-A and LPN-A had to redirect R1 and calm him down and assist him to bed. R1 was put to bed without a gown, because he would not allow the staff to put one on. R1 reported NA-A was "getting rough with him... [NA-A] pushed me and grabbed me because I would not get off the toilet." The interview identified TMA-A did not continue to probe the resident and at this time the charge nurse and co-owner were investigating the incident. R1 was very adamant and did not change his story. Further TMA-A stated NA-A "was pretty stern" with the residents.

-9/8/20, at 2:00 p.m. NA-A stated on 9/4/20, R1 was wandering down to other residents rooms and NA-A had to "drag" R1 out. R1 was confused that evening and stated he was looking for dead bodies and was saying other strange things.

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NA-A was helping get R1 ready for bed that evening. R1 was seated on the toilet and NA-A was trying to put a gown on over R1's head. R1 did not want to put on the gown because it was wet and he was cold. R1 became really upset and "whipped" the gown off. NA-A stated he then went to grab three more gowns but R1 did not want them and stated to NA-A "you don't control me, don't tell me what to do." NA-A stated he then grabbed R1's arms as R1 was trying to "whip" the gown off his head and the gown got caught on R1's ear. NA-A then demonstrated to the administrator his actions. R1 had his arms above his head trying to untie the gown to remove it and NA-A stated, "I looked him in the eyes and grabbed his arms adn [sic] said [R1] listen to me?" NA-A grabbed his arms and tapped him on the head. Then NA-A left the room to get help from another staff member. The other staff member entered the room and told NA-A they would handle it. NA-A reported to the other staff member "[R1] is trying to accuse me of giving him those bruises on his arms." NA-A stated there was a large bruise on his right arm already and was present all week. However, after NA-A changed his story multiple times regarding if the bruising was present or not, NA-A stated the other three bruises were from NA-A. NA-A denied giving R1 the larger bruise on R1's right forearm.

- 9/8/20, at 3:45 p.m. licensed practical nurse (LPN)-A reported on 9/4/20, NA-A asked LPN-A to assist with escorting NA-A out of the bathroom as NA-A was not able to. When LPN-A entered the room R1 was in the bathroom sitting on the toilet and appeared to be "agitated." LPN-A assured R1 everything was ok and LPN-A would help R1 to their bed. R1 told LPN-A that NA-A wanted R1 to take a bath and was trying to put a

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gown on him. LPN-A clarified R1 was attempting to be toileted and get ready for bed and no bath was involved that night. R1 proceeded to tell LPN-A that NA-A was trying to get a towel away from him, but there was no towel; however, there was a gown. R1 then stated, while pointing at his arms, that [NA-A] had "grabbed on to my arm and made a twisting motion." LPN-A stated the area on R1's arm was slightly red. LPN-A was able to calm R1 down and encourage R1 into bed. On 9/5/20, LPN-A was asked to obtain a skin assessment following R1's bath. While completing the skin assessment LPN-A observed bruising on R1's bilateral forearms. LPN-A asked R1 what happened to his arms. R1 stated, "Exactly the same thing as he did the night prior." LPN-A was not sure if any documentation had been completed regarding the bruising. LPN-A checked R1's record and identified the bruising had not been previously documented and alerted the charge nurse. LPN-A let the charge nurse know the bruising was new and could possibly be from the evening before. The charge nurse contacted the co-owner and registered nurse (RN)-B of the facility. R1 was able to explain to the charge nurse and RN-B the exact same story. RN-B then contacted the administrator of the facility.

R1 's Physician Order Report signed 9/4/20, did not identify R1 was receiving any blood thinning medication, which could cause an increase in bleeding and bruising.

R1 's progress note(s) identified the following:

- There were no progress notes documented on 9/4/20.

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- 9/5/20, at 9:58 p.m. a skin assessment was completed and bruises were noted on the right and left forearms. The bruises on right forearm measured 6.5 cm x 7 cm , 2 cm x 1.4 cm. The bruise on the left forearm measured 2 cm x 1 cm.

R1's weekly Bath Skin Assessment identified the following:

- 8/22/20, R1's skin was intact and without any identified bruising.

- 9/5/20, R1 had bruises to the right and left forearm and the registered nurse was notified per facility policy.

-9/12/20, R1 had bruising to the right and left forearm.

NA-A's Employee Discipline Report signed 9/10/20, identified NA-A was discharged from employment at the facility. The report identified the following: NA-A had completed annual training on vulnerable adult/abuse/suspicion of a crime training on 4/27/20. "Based on interviews with staff, resident and team members, [NA-A] admits that he grabbed resident's arms during an interaction in the resident's restroom the evening of 9/4/2020 forcefully holding resident creating significant bruising on forearms of resident. Resident consistently identified [NA-A] created the bruises. Resident has bruising to bilateral arms. Interaction between [NA-A] and resident caused physical harm, and emotional distress to the resident."

During interview on 9/14/20, at 3:05 p.m. R3 stated most of the staff were good but " [NA-A], kinda pushy, we didn't like each other." R3 stated

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NA-A had never abused or harmed him in anyway and felt safe at the facility. R3 's significant change MDS dated 6/22/20, identified R3 had moderate cognitive impairment.

On 9/14/20, at 3:07 p.m. the administrator was in the hallway on second floor and identified NA-A was always scheduled on the second floor, on the Canary Lane, however, helped with transferring and answering call lights of all the residents on the second floor.

The facility provided untitled resident listing dated 9/14/20, identified 37 residents resided on the second floor.

On 9/15/20, at 9:26 a.m. a message was left for NA-A. A phone call was not returned.

During interview on 9/15/20, at 10:44 a.m. LPN-A stated on the evening of 9/4/20, NA-A had requested her help with R1 because they were refusing to put a gown on to go to bed. LPN-A stated R1 was "agitated" and was not making much sense as 9/4/20, was not R1's bath day. She assisted R1 from the bathroom to bed. R1 made a comment that NA-A had twisted his arm. LPN-A stated she then observed R1's arm and it was slightly red. R1 demonstrated a twisting motion with his hands identifying how NA-A had twisted his arm. LPN-A stated she did not report the incident on 9/4/20, to the charge nurse or administrator at that time because she did not see an injury and did not think NA-A would "be physical" with a resident. She thought maybe they just got into an "argument." She did complete the skin check on 9/5/20, and observed the bruising on R1's forearms. She then reported the incident immediately to the charge nurse who then

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reported the incident to administration. LPN-A stated she should have reported the incident on 9/4/20, when R1 stated NA-A had twisted his arm. LPN-A had not received any recent education on behavior management or identifying and reporting abuse.

During interview on 9/15/20, at 10:53 a.m. RN-A stated they received abuse training in multiple forms annually. If she is made aware of any potential abuse concern they report immediately to the administrator. She was made aware of R1's bruising, however, it had already been reported and was in the process of being investigated. She had not received any recent education on behavior management or identifying and reporting abuse. No other residents had alleged abuse to her knowledge.

During interview on 9/15/20, at 11:05 a.m. LPN-B stated she was aware R1 alleged abuse against NA-A because she went to give R1 his pills the morning of 9/6/20 and he told her NA-A was mean to him. R1 pulled up his sleeves and showed her the bruises. R1 stated NA-A had twisted his arm. LPN-B was not aware of the situation prior to starting her shift so she reported the incident immediately to RN-A, however, they found out the administrator was already aware and it was being investigated. LPN-B had not been provided any recent training on behavior management or identifying and reporting abuse.

On 9/15/20, at 11:34 a.m. the administrator, DON and LSW were interviewed regarding the allegation of abuse. The administrator stated he was called on 9/5/20, because R1 had bruising not previously observed and R1 reported NA-A had caused the bruises. Upon talking with LPN-A

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on 9/5/20, she stated in hindsight she should have reported the incident on 9/4/20; however, R1 was flustered and mumbling and there was not a lot of discernable information from R1. LPN-A did identify R1's right forearm was a "little red" on 9/4/20. I don't think at the time she thought NA-A did anything wrong to R1 until 9/5/20, when the bruising was observed. The administrator stated he would expect to be notified immediately of potential abuse on any suspicion level. There did not need to be bruising to identify if someone was abused. NA-A had worked on 9/4/20, until 10:30 p.m. and then did not work again in the facility until he was terminated on 9/10/20, following the facility investigation. During the facility interview with NA-A he altered his story about the bruises a few different times. When they pointed out the fingerprint sized bruises NA-A admitted to causing at least three of the bruises when trying to calm him down. The facility identified NA-A had "infringed upon the residents rights" by "restraining inappropriately." That is not how the facility expected the staff to treat residents. The facility trains on abuse annually and as needed. There were no previous concerns with NA-A. If LPN-A had reported the allegation immediately on 9/4/20, NA-A would have been removed from the shift immediately and not allowed to continue working. The DON stated R1 was not receiving any medication that could increase his bleeding potential. They had not reeducated any of the staff on behavior management or identifying or reporting abuse. The DON further stated they had a virtual nursing staff meeting set up for later that week on 9/17/20, and that R1 did not have any residual effects.

The undated Virtual Staff Meeting Agenda,

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identified a staff meeting was being held on 9/17/20, and included vulnerable adult reporting. However, the meeting agenda did not include how to identify potential abuse and how to handle resident behaviors when refusing cares.

On 9/16/20, at 7:35 a.m. the administrator stated while interviewing all interviewable residents, R2 reported an allegation of abuse by NA-A. The incident was reported immediately to the SA and was being investigated.

On 9/16/20, at 7:50 a.m. R2 stated NA-A was "very acidic" and NA-A had physically hurt him. NA-A poked him in the chest, face and forehead with his finger. NA-A was a "Mr. know it all." R2 further stated he never reported NA-A had poked him as he thought NA-A was just singling R2 out. R2 stated he felt safe and would try and think about more details and report them to the LSW. R2 could not provide any dates or frequency of the alleged physical abuse. There were no marks or bruising to R2's face. R2's annual MDS dated 8/14/20, identified R2 had moderate cognitive impairment and had a diagnosis of schizophrenia.

During interview on 9/16/20, at 8:59 a.m. RN-B stated she had been assisting with resident cares since March 2020, when the COVID-19 restrictions were implemented. R1 had been having some increase behaviors and needed more cues with toileting in the recent months. RN-B did not feel LPN-A could have known R1 was alleging abuse against NA-A on 9/4/20, as his confusion was not abnormal. RN-B was not aware LPN-A had stated she was aware on 9/4/20, that R1 was "agitated" that evening and required intervention of LPN-A to assist him to bed that evening. She was also not aware R1

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stated on 9/4/20, to LPN-A, that NA-A had twisted his arm. RN-B was also not aware LPN-A assessed his arm and identified it was slightly red. The facility had never suspected NA-A of any abuse prior to this incident.

The facility Abuse Prohibition policy revised 7/15/20, identified each resident had the right to be free from abuse and residents should not be subjected to abuse by anyone including facility team members. Abuse included hitting, slapping, kicking, biting, scratching, pushing or any other corporal punishment. Further, the policy identified an allegation of abuse would be reported immediately, to the administrator and SA (state agency), but not later than two hours after forming the suspicion of abuse. Residents would be protected from harm during the investigation. The facility would accomplish this by removing the alleged perpetrator from the facility, if necessary; moving the resident to a more easily observed area if necessary; involving law enforcement if necessary; increasing direct "eyes on" monitoring if necessary. Further the policy identified any person with the knowledge or suspicion of suspected violations shall report immediately, without fear of reprisal if the report is made in good faith.

The facility Behavior Management and Monitoring policy revised 9/16/20, identified staff education on behaviors would be provided annually for those providing direct care. Staff would manage behaviors with the goal of maintaining and or improving quality of life.

The IJ was removed on 9/16/20, at 8:33 a.m. when it could be verified through interview and document review the facility had educated staff in

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F 600	Continued From page 14 how to identify potential abuse, immediately report abuse along with resident behavior education. In addition, the facility interviewed all interviewable residents and completed skin assessments on all non-interviewable residents to identify potential scope of abuse.	F 600		
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 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	F 609		10/15/20

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	245257	A. BUILDING _____ B. WING _____	C 09/17/2020

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 609	Continued From page 15 by: Based on interview and document review, the facility failed to ensure an allegation of physical abuse was reported to the State Agency (SA) within two hours of the allegation for 1 or 2 residents (R1) who had alleged physical abuse by a staff member. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/17/20, identified R1 was cognitively intact and usually made themselves understood; however, had some difficulty communicating some words or finish their thoughts but was able when prompted. R1 required extensive assistance from staff to complete toileting, transferring and bed mobility tasks. The MDS identified a diagnosis of dementia. An incident report was submitted to the SA on 9/5/20, at 8:41 p.m. by the facility administrator. The incident report identified an allegation of physical abuse resulting in a bruise of unknown origin. The date and time of the incident was identified on 9/4/20, at 9:00 p.m. The description of the incident was identified as "Bruise on right forearm identified during weekly skin assessment of resident by LPN [licensed practical nurse]. Resident states his arm was grabbed by a CNA [nursing assistant] the previous evening while in the restroom prior to bed. Alleged perpetrator is not in facility or on the schedule until afternoon of 9/8/2020. Resident in normal mindset and mood. Not worried about safety at this time. Further investigation to be completed." On 9/14/20, at 2:36 p.m. R1 was observed seated in his recliner with his feet elevated and had on a	F 609	F609 Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) It is our intent to keep residents free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. In the event of any of the above situations, SOCC has updated and implemented policies and procedures that require allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported, 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. SOCC team members and volunteers are instructed to immediately report all witnessed and suspected incidents of abuse, neglect or misappropriation of resident property to a supervisor, Director of Nursing, Administrator/Designee. If abuse is alleged, immediate but no later than two hours reporting to the Nursing Home Incident Reporting Website is to occur. Interventions to keep alleged victim safe from further harm will be appropriately taken by facility team members/supervisors. A. Provide one-on-one education with	

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F 609	Continued From page 16 long sleeved shirt. R1 stated nursing assistant (NA)-A had "purposely" gave him bruises on his arms when he refused to take a bath. R1 pulled up his sleeve and there was a significant bruise to his right forearm about the size of a baseball with three smaller bruises protruding from the larger bruise, this bruise was purple/ maroon in color. R1 then pulled up his left sleeve and identified a small thumb print sized bruise to his left forearm, the bruise was also purple/ maroon in color. R1 stated other staff were aware the evening of the incident because someone came in to assist him and there was a lot of yelling going on. During interview on 9/15/20, at 10:44 a.m. LPN-A stated on the evening of 9/4/20, NA-A had requested her help with R1 because they were refusing to put a gown on to go to bed. LPN-A stated R1 was "agitated" and was not making much sense as 9/4/20, was not R1's bath day. She assisted R1 from the bathroom to bed. R1 made a comment that NA-A had twisted his arm. LPN-A stated she then observed R1's arm and it was slightly red. R1 demonstrated a twisting motion with their hands identifying how NA-A had twisted his arm. LPN-A stated she did not report the incident on 9/4/20, to the charge nurse or administrator at that time because she did not see an injury and did not think NA-A would "be physical" with a resident. She did complete the skin check on 9/5/20, and observed the bruising on R1's forearms. She then reported the incident immediately to the charge nurse who then reported the incident to administration. LPN-A stated she should have reported the incident on 9/4/20, when R1 stated NA-A had twisted his arm. During interview on 9/15/20, at 11:34 a.m. the	F 609	LPN-A on the requirement of mandated reporting requirements related to suspicion of abuse. B. Vulnerable adult education and mandated reporting requirements was provided on 9/15/20 to all team members. Vulnerable adult/mandated reporter education will occur upon hire, annually and in department meetings throughout the year. Education also provided included Abuse Prevention in Persons with Dementia via online training module. C. The Resident Vulnerable Adult Assessment that is completed upon admission and annually was changed to be completed upon admission and quarterly thereafter. D. Audits that include simulated scenarios with documented times of allegations or suspicion of abuse and notification of administrator will be conducted by the DON/designee for 3 months and on a random basis to ensure immediate reporting is completed based on the simulated scenarios. Findings will be reported to the QAPI committee.	

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F 609	Continued From page 17 administrator stated he was called on 9/5/20, because R1 had bruising not previously observed and R1 reported NA-A had caused the bruises. Upon talking with LPN-A on 9/5/20, she stated in hindsight she should have reported the incident on 9/4/20; however, R1 was flustered and mumbling and there was not a lot of discernable information from R1. LPN-A did identify R1's right forearm was a "little red" on 9/4/20. I don't think at the time she thought NA-A did anything wrong to R1 until 9/5/20, when the bruising was observed. The administrator stated he would expect to be notified immediately of potential abuse on any suspicion level. There did not need to be bruising to identify if someone was abused. The facility policy Abuse Prohibition revised 7/15/20, identified each resident had the right to be free from abuse and residents should not be subjected to abuse by anyone including facility team members. Abuse included hitting, slapping, kicking, biting, scratching, pushing or any other corporal punishment. Further, the policy identified an allegation of abuse would be reported immediately, to the administrator and SA, but not later than two hours after forming the suspicion of abuse.	F 609		

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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 9/14/20, through 9/17/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be in compliance with the MN State Licensure. The following complaint was found to be SUBSTANTIATED: H5257015C, however NO	2 000		

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2 000	Continued From page 1 licensing orders were issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required for state licensure, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 5, 2020

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

Re: Event ID: WYB611

Dear Administrator:

The above facility survey was completed on September 17, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File