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

Electronically delivered
November 10, 2021

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

RE: CCN: 245257
Cycle Start Date: October 22, 2021

Dear Administrator:

On October 20, 2021, we informed you of imposed enforcement remedies.

On October 22, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

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

This Department continues to recommend 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 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.

As we notified you in our letter of October 20, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 19, 2021.

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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 (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

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/ 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,

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 10/22/2021

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	INITIAL COMMENTS On 10/22/21, a standard abbreviated survey was conducted at your facility. 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, however related deficiencies were cited. H5257028C (MN77662), with a deficiency cited at F610. 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 regulations has been attained.	F 000		
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.	F 610		11/26/21

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

Electronically Signed | 11/20/2021

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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F 610	Continued From page 1 §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 document review, the facility failed to thoroughly investigate an allegation of physical abuse for 1 of 1 resident (R1) who reported a staff member squeezed his hand resulting in bruising on hand. Findings include: R1's annual Minimal Data Set (MDS) dated 9/28/21, indicated R1 had diagnoses which included urinary tract infection, depression and severe cognitive impairment. Further review of MDS, indicated R1 required extensive assistance of two staff members for bed mobility, transfers, toileting. R1's care plan printed 10/22/21, indicated R1 was at risk for maltreatment related to "confusion from dx [diagnosis] dementia, his orientation to place, time varies at times. [R1] is also at risk for maltreatment related to falls, has a past hx [history] of a frequent faller, will self-transfer at times. [R1] needs staff supervision at times." Review of facility report made to the State Agency (SA) dated 10/14/21, at 2:00 p.m. indicated "Lane nurse reported on 10-14-21 at 12:00 p.m. to RN that resident's hand has a new bruise on top. Lane nurse reported that resident stated 'a black	F 610	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. F610 Investigate/Prevent/Correct Alleged Violations All VA incidents are investigated and will now include an Investigation Guidelines Checklist which will be included in the Abuse Prohibition policy. This checklist will be reviewed by the Administrator, Assistant Administrator, Director of Nursing and Social Services to determine any further necessary steps for a thorough investigation. The IDT consisting of the Administrator, Asst Administrator, DON, Social Services, and Nurse Leaders will be educated on the new checklist and required to complete education on conducting an abuse investigation. Training will be completed by 11/26/2021 and thereafter annually.	

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F 610	Continued From page 2 woman put on a pair of gloves and then rubbed my hand real hard.' Incident reported immediately to administration for further investigation. Charting and staff interviews reflect resident did not report the bruise or encounter with staff member prior to encounter with lane nurse at 12:00 p.m. on 10-14-21." Further, report indicated alleged perpetrator (AP) removed from schedule until remaining investigation is completed. Review of facility 5-day investigative report to the SA dated 10/19/21, at 3:04 p.m. indicated "Conclusion: based on interview with staff, resident and AP there was no intentional harm done to resident and AP did not cause bruise. Bruise was noted to be there during LPN interaction with resident on 10/13 immediately after AP had asked for her assistance. Resident states he does not feel AP or any staff member caused bruise and denies being harmed. He states he is not afraid of anyone at the facility and was comfortable with AP working with him." However, reported lacked evidence that other residents were interviewed, who were under the direct care of the AP, to ensure no additional victims and no other concerns related to abuse were identified. On 10/22/21, at 1:08 p.m. R1 stated "it was a piece of furniture she was going to take, and she wouldn't let me have it. She was jerking and jerking it. I kept pulling on it and tightening my grip on it and every time I tightened my grip she would pull more and harder. She had both hands holding my hand. That is how I got this bruise here and it got to the point where it was tight and hurt so bad, I let loose." On 10/22/21, at 2:34 p.m. director of nursing	F 610	VA investigations will be reviewed as a team consisting of the Administrator, Assistant Administrator, Director of Nursing and Social Services reviewing for accuracy and completeness. All VA investigations will be brought to the monthly QAPI meeting beginning 12/7/2021, and monthly thereafter until QAPI committee determines that investigations are being conducted per policy.	

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F 610	Continued From page 3	F 610		

(DON) stated she was made aware of the allegation on 10/14/21, by the Administrator. Further, DON indicated staff were interviewed and "we interviewed residents through the five day there were 5-7 residents we interviewed. I thought it was in some of these reports. I would have to look to see if we have anything else." DON confirmed there were no other residents interviewed, who were under the direct care of the AP, during the investigation but residents are interviewed related to abuse "periodically and during care conferences". DON stated "we spoke with all staff involved and looking at his change and overall status, his history and notes, he said it wasn't intentional and he was not afraid of her and that is what we looked at to make those decisions that we did. It was not substantiated for abuse." In addition, DON indicated interviewing other residents would be important "to see if any residents have had issues with any kind of abuse and that is why we have a system."

On 10/22/21, at 3:27 p.m. licensed social worker (LSW) indicated she was not apart of the 5- day investigation for the alleged abuse and was not sure who completed the full investigation "it was during the interim when the administration was in a leadership training". Further, LSW indicated the facility's process for investigating allegations of abuse included starting interviews with the resident involved in the allegation and then staff involved, alleged perpetrator, and other potential witnesses. In addition, LSW stated "I don't know if I would go to each resident. I would start with the resident and the AP and if I felt the need to expand as appropriate I would." LSW indicated interviewing other residents would be important "because they see stuff too".

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F 610	Continued From page 4 On 10/22/21, at 3:37 p.m. when asked what the facility's process for investigation an allegation of abuse was, Administrator indicated "upon reporting we assess the situation and determine if it's a reportable issue and determine who is involved. If there is abuse involved, they [AP] are suspended until a thorough investigation is completed upon talking with the first responders." Further, Administrator indicated DON completed the investigation and interviewed "staff that interacted with [R1] and [R1] himself and spoke with [AP] to come to the conclusion." When asked if other residents on the unit were interviewed during the investigation, Administrator stated "in previous cases we talk with other resident that are coherent to verify that they are safe and feel safe and haven't had anyone harm them. I would say it depends on the scenario if the investigation leads to serious concern about abuse it would expand further investigation if it's identifiable that there is no additional risk which there was not." Further, Administrator indicated there was an incident of "misunderstanding" that was reported involving another resident and the AP and "there was no abuse concerns at that time maybe that is why we didn't interview other residents. That time there was no concerns on that level I am thinking because we had done it a week or two prior to that it was identified that there was not concern with the other residents in the past so that's the path we took." In addition, Administration indicated the importance of interviewing other residents who were under the care of the AP was to ensure "they are safe and there is not an issue going on". On 10/22/21, at approximately 4:00 p.m. Administrator indicated staff "go where the investigation leads them" and R1 denied intention	F 610		

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F 610	Continued From page 5 of harm by the AP when interviewed and stated the AP "did not mean to do it". Further, Administrator indicated if R1 "were still angry that would have precipitated it to go further." Review of facility policy titled Abuse Prohibition revised 6/7/21, indicated "the intent of this policy is to provide protections for the health, welfare and rights of each resident residing at St Otto's Care Center. St Otto's will identify events that may constitute maltreatment such as abuse, neglect and misappropriation of resident property and determine the direction of the event. This will be accomplished by following the Abuse Prevention Plan, providing in-service education, completing a thorough assessment and investigation, and involving outside experts as needed, including, but not limited to, legal assistance and law enforcement." Further review of facility policy, indicated "resident/daycare clients, the alleged perpetrator, and other team members will be protected from harm during an investigation."	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 10, 2021

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

Re: Event ID: Z46111

Dear Administrator:

The above facility survey was completed on October 22, 2021 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,

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

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	00817	A. BUILDING: _____ B. WING _____	C 10/22/2021

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

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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 10/22/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H5257028C (MN77662), however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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, it is required that the facility acknowledge receipt of the electronic documents.	2 000		