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	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ottos Care Center	920 Southeast 4th Street Little Falls, MN 56345

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority (SMHA)) for 1 of 1 resident (R76) with new onset mental illness. Findings include: R76's Census Record indicated admission on 4/17/24. R76's quarterly Minimum Data Set (MDS) dated [DATE], identified R76 had intact cognition and required assistance with all activities of daily living (ADL)'s. R76's diagnoses included hypertension, urinary tract infection, diabetes mellitus, hyperlipidemia, depression, chronic obstructive pulmonary disease (COPD), hypothyroidism, polyarthritis, and major depressive disorder. MDS also indicated R76 hallucinated and had delusions. R76's prior MDS's had no identification of a psychotic disorder. R76's psychiatric provider visit note dated 9/12/24, identified R76 was diagnosed with two new mental health diagnoses: Major neural cognitive deficits secondary to Alzheimer's with behavioral disturbance and Severe episode of recurrent major depressive disorder with psychotic features. R76's care plan printed 11/6/24, identified resident received psychotropic medication related to depression, recent major life events/lifestyle changes. R2 had a history of hallucinations and delusional/paranoid thinking such as; hearing voices of specific staff coming from R76's television, saying bad things about her, thinks two staff are out to get her, worrying excessively at times about what people will think of her. R76's Initial Pre-Admission Screening (PAS) Results,dated 4/16/24, did not identify a diagnosis of mental illness, nor the need for a Level II PASARR to be completed. During interview on 11/8/24 at 10:03 a.m., social worker (SW) stated she was not aware of R76's new mental health diagnoses. SW stated, had she been made aware, she would have contacted Senior Linkage Line (SLL) for guidance if a resident review was required. SW confirmed there were no new diagnoses entered into R76's health record. Therefore, she did not complete any follow up with the county. SW stated it was important for reassessment to occur to see what other services may be available for R76 to ensure the best possible care. (continued on next page)

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

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/8/24 at 10:14 a.m., Senior Linkage Line representative (SLLR) stated R76 would need to have a resident review done due to her new mental health symptoms. SLLR stated facility should contact the county to have a resident review completed. SLLR referred to their policy regarding when a resident review should be completed which indicated if there is a change in the individual's situation that significantly changes the person's mental health symptoms or their need for mental health services. SLLR stated the intent of the resident review was to ensure the resident has been screened, they have access to services and to ensure where the resident was residing was appropriate. The facility Admission policy dated 2/4/21, indicated the social worker is responsible for ensuring proper preadmission screening was completed by the referring agency to the Senior Linkage Line for PASARR Level I and II screenings to provide appropriate services and rule out any mental health/MR/DD diagnosis that may require further follow up. The Social Worker will follow up on any MR/DD or mental health needs identified to ensure proper services remain in place and/or are documented in the chart.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure provider orders were processed for 1 of 1 resident (R76) reviewed for change in mental status. Findings include: R76's quarterly Minimum Data Set (MDS) dated [DATE], identified R76 had intact cognition and required assistance with all activities of daily living (ADL)'s. R76's diagnoses included hypertension, urinary tract infection, diabetes mellitus, hyperlipidemia, depression, chronic obstructive pulmonary disease (COPD), hypothyroidism, polyarthritis, and major depressive disorder. PHQ9 score was 13. MDS also indicated R76 hallucinated and delusions. R76's psychiatric provider visit note dated 9/12/24, indicated due to the symptoms reviewed in the HPI (history of present illness), current diagnose should include: major neural cognitive deficits secondary to Alzheimer's with behavioral disturbance, and severe episode of recurrent major depressive disorder with psychotic features. R76's psychiatric provider visit note dated 10/15/24, stated brexipiprazole for agitation and restlessness. R76 had hallucinations and delusions impacting her mental and physical well-being. The benefits of the medication far out weight the risks. Brexipiprazole 0.25 milligrams (mg) oral tablet for major neural cognitive deficits secondary to Alzheimer's with behavioral disturbance as well as severe episode of recurrent major depressive disorder with psychotic features. During record review, the following diagnoses were not listed in R76's medical record: major neural cognitive deficits secondary to Alzheimer's with behavioral disturbance as well as severe episode of recurrent major depressive disorder with psychotic features. R76's physician orders included orders for Rexulti (antipsychotic) 0.25 milligram (mg) by mouth at bedtime for major depressive disorder for seven days initiated on 10/15/24 and increased to 0.5 mg at bedtime on 10/22/24. During interview on 11/8/24 at 10:52 a.m., registered nurse (RN)-B stated the health unit coordinator (HUC) printed off new provider visit notes and the RN reviewed them for anything new or anything that might have been missed. RN-B stated whatever nurse that was on duty was the one who was responsible for reviewing orders/visit notes and making any changes needed. During interview on 11/8/24 at 11:57 a.m., director of nursing (DON) and assistant director of nursing (ADON) stated the HUC printed out provider visit notes/dictations when they were available, and the RN reviewed them for anything new or something that stood out. DON and ADON confirmed that neither diagnosis was processed. Neither was listed on R76's current diagnoses. DON and ADON stated it was important to ensure all diagnoses were listed so everyone knows how to care for the resident at the best of their ability for all of the residents conditions. Important to see the big picture. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Physician orders and Progress Notes policy, dated 11/15/21, indicated orders written by physician will be transcribed by nurse and inputted into EMAR (electronic medication administration record) by HUC and then verified for completeness by nurse. Completeness to include resident name, physician name, date, time of order, order compete with medication name, dosage/treatment and time, frequency, diagnosis for medication, legible to interpret, stop date if applicable and signature/credential of nurse. Physician progress notes will be printed off and placed in residents' chart when available.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49657 Based on interview, and document review, the facility failed to implement interventions to prevent further development of decreased range of motion for 2 of 3 residents (R5 and R10) reviewed for positioning and mobility. Findings include: R5's quarterly Minimum Data Set (MDS) dated [DATE], indicated R5 was admitted to the facility on [DATE] and had a moderate cognitive impairment and diagnoses of diabetes. R5's physical therapy (PT) discharge summary dated 7/14/21 through 8/13/21, indicated lower extremity (LE) exercises, LE ROM, and LE bike to maintain current level of performance, and prevent decline were recommended. R5's care plan dated 10/23/24, indicated pulley exercises/or upper extremity (UE) active range of motion program (AROM) to be completed 3-4 times a week and twice a day (BID) and a LE AROM program to be completed 3-4 times a week BID. The facility document titled Point of Care History dated 9/5/24 through 11/5/24, reviewed 60 days of AROM documentation and included staff documentation for the number of minutes, and frequency of completion of AROM programs each day. It indicated R5's AROM programs had only been completed BID on two of the sixty days reviewed, on the other days it was documented as being completed only once, not answered, or not preformed. R5's medical record lacked any documentation as to why the AROM programs were not completed or the rational for them not being performed. R10's quarterly MDS dated [DATE], indicated R10 was admitted on [DATE], cognitively intact, and diagnoses included: coronary artery disease (CAD) (hardening of the arteries of the heart), heart failure (HF) (heart does not pump appropriately), neurogenic bladder (bladder does not contract when stimulated by the brain, loss of control), dementia, cerebral vascular accident (CVA) (stroke), hemiplegia or hemiparesis (inability to move one side of the body), paraplegia (loss of ability to move body), and depression. R10's PT discharge summary dated 6/26/23 through 7/25/23, indicated a restorative program of ROM to the right UE, and right LE were recommended to prevent contractures and increase patient comfort. R10's care plan dated 10/2/24, indicated UE AROM to be completed 3-4 times a week BID and a LE PROM program to be completed 3-4 times a week BID. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document titled Point of Care History dated 9/5/24 through 11/5/24, reviewed 60 days of AROM and PROM documentation and included staff documentation for the number of minutes, and frequency of completion of these AROM/PROM programs each day. It indicated R10's AROM and PROM program's had been completed BID on two of the sixty days reviewed for PROM, and three of the sixty days reviewed for AROM. On the other days it was documented as being completed once, not answered, not preformed, or refused. R10's medical record lacked any documentation as to why the AROM/PROM programs were not completed other than refused on some occasions. On 11/7/24 at 1:27 p.m., nursing assistant (NA)-A stated the NA's completed the ROM programs or the restorative aide staff if they were available, and would document unknown if they did not get the resident up, or were unsure if it was completed or done by another staff member. If they knew it was not completed, they would chart no information or did not occur. NA-A stated they typically would not report it if not completed, if someone from restorative was working they would assume the other staff had completed it. On 11/7/24 at 3:51 p.m., the lead restorative licensed practical nurse (LPN)-A, stated six rehab team members and NA's were responsible for completing and documenting ROM programs in the point of care section of matrix. LPN-A stated they expected the ROM programs to be offered as ordered 3-4 times a week and BID. LPN-A stated if they documented not preformed, or not offered they simply did not have time to do it or did not complete the ROM programs. LPN-A stated it was important to complete ROM programs to prevent contractures, and not lose their ability to move. On 11/7/24 at 5:20 p.m., the director of nursing (DON) stated they expected ROM programs were completed 3-4 times a week and BID to prevent contractures and decreased abilities. The Restorative Nursing Policy last reviewed 10/24, indicated restorative programs are expected to be completed to maintain the resident at their highest level of functioning.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview, and document review, the facility failed to implement and monitor orthostatic blood pressures and obtain a baseline AIMS (abnormal involuntary movement scale) with the initiation of an antipsychotic medication for 1 of 3 residents (R76) reviewed for antipsychotic medications. Findings include: R76's quarterly Minimum Data Set (MDS) dated [DATE], identified R76 had intact cognition and required assistance with all activities of daily living (ADL)'s. R76's diagnoses included hypertension, urinary tract infection, diabetes mellitus, hyperlipidemia, depression, chronic obstructive pulmonary disease (COPD), hypothyroidism, polyarthritis, and major depressive disorder. PHQ9 score was 13. MDS also indicated R76 hallucinated and delusions. MDS indicated R76 needed supervision or touching assistance with transfers and ambulation. R76's physician orders included orders for Rexulti (antipsychotic) 0.25 milligram (mg) by mouth at bedtime for major depressive disorder for seven days that started on 10/15/24 and was then increased to 0.5 mg at bedtime on 10/22/24. R76's medical record was reviewed and lacked any evidence orthostatic blood pressures and AIMS assessment were initiated and/or had been obtained for R76 with the initiation of an antipsychotic medication. During observation on 11/4/24 at 1:14 p.m., R76 was in her room and observed to self transferring to her wheelchair with no staff present. During interview on 11/5/24 at 10:32 a.m., consultant pharmacist (CP) stated any resident on an antipsychotic medication should have orthostatic blood pressures and a baseline AIMS assessment initiated upon start of an antipsychotic medication. Pharmacist stated orthostatic blood pressures and AIMS assessment were important to monitor for side effects as it helped evaluate the risks verses benefits of the medication and helped the facility see the big picture. CP also stated it was important to monitor side effects of antipsychotic medications due to postural hypotension (lowering of the blood pressure that can cause lightheadedness, dizziness, and blurred vision) being one of the major side effects and would put the resident at a higher risk for falls when taking these medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/7/24 at 12:14 p.m., registered nurse (RN)-A stated orthostatic blood pressures and a baseline AIMS assessment were completed when antipsychotic medications were started and then every 6 months. RN-A stated AIMS assessment were important to complete so you can have early detection of side effects of the antipsychotic medications that may be irreversible. RN-A stated it was important to monitor orthostatic blood pressures for side effects that could affect the resident's mobility. RN-A stated R76's Rexulti was started on 10/15/24 and confirmed neither orthostatic blood pressures or a baseline AIMS assessment had not been initiated and/or completed for R76. RN-A confirmed R76 had a history of orthostatic hypertension so orthostatic blood pressures should have been initiated for R76. During interview on 11/8/24 at 11:57 a.m., director of nursing (DON) and assistant director of nursing (ADON) stated monitoring for antipsychotic medications consisted of orthostatic blood pressures and a baseline AIMS assessment. DON and ADON stated that both orthostatic blood pressures and a baseline AIMS assessment should have been initiated at the start of an antipsychotic medication to monitor for side effects of the antipsychotic medication. DON and ADON confirmed that there were no orders for orthostatic blood pressures in place and a baseline AIMS assessment were not obtained/completed for R76. The facility Orthostatic Hypotension policy, dated 8/15/22, indicated elderly have a natural incidence of postural hypotension and the possibility of post prandial hypotension. Orthostatic hypotension (OH) can be a consequence of normal aging, disease, and/or drug effect. Recommendations: OH blood pressures taken for initiation of antipsychotic medications. The facility Antipsychotic Drug Indication Criteria policy, dated 3/2024, indicated if a resident is admitted already using an antipsychotic or, if facility is considering starting an antipsychotic medication, then side effect monitoring procedure established BEFORE medication initiated. An AIMS should be completed every 6 months on resident's taking an antipsychotic medication. Monitor orthostatic blood pressures at baseline and every six months in conjunction with the AIMS.