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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: 10R2

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00922

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245464**
2.STATE VENDOR OR MEDICAID NO.
(L2) **363670400**

3. NAME AND ADDRESS OF FACILITY
(L3) **OSTRANDER CARE AND REHAB**
(L4) **305 MINNESOTA STREET**
(L5) **OSTRANDER, MN** (L6) **55961**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **4/4/2019** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

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

12.Total Facility Beds **25** (L18)
13.Total Certified Beds **25** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
X Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 25 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, Unit Supervisor 4/10/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/10/2019 (L20)

**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
**04/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00040**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

CMS Certification Number (CCN): 245464

April 9, 2019

Administrator
Ostrander Care and Rehab
305 Minnesota Street
Ostrander, MN 55961

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 26, 2019 the above facility is certified for:

25 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 25 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
April 9, 2019

Administrator
Ostrander Care and Rehab
305 Minnesota Street
Ostrander, MN 55961

RE: Project Numbers S5464031, H5464005C

Dear Administrator:

On April 4, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 29, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** ID: 10R2

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** Facility ID: 00922

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245464**
2.STATE VENDOR OR MEDICAID NO.
(L2) **363670400**

3. NAME AND ADDRESS OF FACILITY
(L3) **OSTRANDER CARE AND REHAB**
(L4) **305 MINNESOTA STREET**
(L5) **OSTRANDER, MN** (L6) **55961**

4. TYPE OF ACTION: **2** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/14/2019** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| **01 Hospital** | **05 HHA** | **09 ESRD** | **13 PTIP** | **22 CLIA** |
| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

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

12.Total Facility Beds **25** (L18)
13.Total Certified Beds **25** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 25 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 03/25/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/09/2019 (L20)

**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
**04/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00040**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 8, 2019

Administrator
Ostrander Care and Rehabilitation
305 Minnesota Street
Ostrander, MN 55961

RE: Project Numbers S5464031, H5464006C, H5464005C

Dear Administrator:

On February 14, 2019, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the February 14, 2019 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5464006C that was found to be substantiated.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the February 14, 2019 standard survey the Minnesota Department of Health, completed an investigation of complaint number H5464005C that was found to be unsubstantiated.

## OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is March 26, 2019.

## 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.

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

## 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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 14, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 14, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.**

## 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 02/10/19 through 02/14/19, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| E 006 SS=C | Plan Based on All Hazards Risk Assessment<br>CFR(s): 483.73(a)(1)-(2)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*<br><br>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.<br><br>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.<br><br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies | E 006 | | 3/26/19 |

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

Electronically Signed | 03/18/2019

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 006 | Continued From page 1<br>that would affect the hospice's ability to provide care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to comprehensively develop emergency preparedness policies and procedures based on the facility completed community risk assessments for all required and facility-identified hazards. This had the potential to affect all 19 residents currently residing in the facility.<br><br>Findings include:<br><br>The facility's Emergency Management Plan, Ostrander Care & Rehab Emergency Operations Plan dated 9/16/2018 identified an undated partially completed "Hazard Vulnerability Analysis." Instructions included evaluate every potential event in each of the three categories of probability, risk, and preparedness and to multiply the ratings for each event in the area of probability, risk and preparedness. The total values, in descending order, will represent the events most in need of organization focus and resources for emergency planning...Probability was completed for each event. Risk was completed on natural events and technological events, but on only 6 of 12 human events identified as low or moderate probability. The preparedness area was completed 1 time out of 37 possibilities. Total scores were not completed.<br><br>Policies and Procedures developed with the emergency operations plan included:<br>-Policy for Emergency Provisions<br>-Procedure for Tracking Residents in the event of an Emergency | E 006 | It is the policy of OCR to update the Hazard Vulnerability Analysis. The Analysis was updated completely and policies were reviewed and updated to include resident elopement, hostage situations, bomb threats & workplace violence. The EOD (emergency operations designee) was educated on the need for annual review and updates to the vulnerable analyses. Administrator and/or EOD will audit this process and findings will be shared at the monthly QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 006 | Continued From page 2<br>-Receiving Facility<br>-Policy for Emergency Preparedness Plan Staff education<br><br>An attachment D was present that included Sheltering-In-Place and Attachment E that identified an Evacuation procedure.<br><br>Areas identified with high total rating scores based on what was completed included: Resident Elopement, Hostage Situation, Bomb threat and Workplace Violence. No policies were present for these identified potential high risk areas.<br><br>During interview on 2/13/19 at 8:20 a.m., the housing director/emergency operations designee (EOD) indicated she was unaware that the hazard vulnerability analysis was not complete or needed to be updated yearly. The EOD further indicated that the current facility hazard vulnerability analysis is from 10/16/15 when they began work on emergency preparedness. The EOD further indicated the policies and procedures that are in the manual are all they have for emergency preparedness and that she has only reviewed the plan on a yearly basis, not the policies or responses that accompany the plan. | E 006 | | |
| E 041 SS=C | Hospital CAH and LTC Emergency Power<br>CFR(s): 483.73(e)<br><br>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. | E 041 | | 3/22/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 3<br><br>§483.73(e), §485.625(e)<br>(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)<br>Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2)<br>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] | E 041 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 4<br>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013. | E 041 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OSTRANDER CARE AND REHAB | 305 MINNESOTA STREET OSTRANDER, MN 55961 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 5<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview the facility failed to ensure the emergency generator had a remote or externally mounted E-stop (emergency stop) button. This had the potential to affect all 19 residents, staff and visitors of the facility.<br><br>Findings Include:<br><br>On facility tour between 11:30 AM and 03:30 PM on 2/12/2019, observations, and staff interview revealed the following:<br><br>( 1 ) During walk-through of the facility observed the emergency generator did not have a remote or externally mounted E-stop ( emergency stop ) button / switch.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | E 041 | The facility has contracted an electrician to install the externally mounted E-stop to the generator. This will be installed by 3/22/2019 per the electrician. The NHA will be responsible to ensure this deficient practice is corrected. | |
| F 000 | INITIAL COMMENTS<br><br>A standard survey was completed at your facility on February 10 through February 14, 2019 by the Minnesota Department of Health. Ostrander Care and Rehab was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>During the standard survey complaints were also investigated: H5464006C was substantiated and | F 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 6<br>resulted in a deficiency at F610. Complaint H5464005C was unsubstantiated.<br><br>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 be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life | F 565 | | 3/26/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 7<br>in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to timely act upon dietary concerns voiced during resident council for 9 of 9 residents (R14, R8, R3, R10, R15, R12, R2, R19, & R7) identified to have attended resident council meetings.<br><br>Findings include:<br><br>Review of the documents from 1/7/2018 through 12/19/2018 titled Resident Council Report listed concerns, suggestions, complaints, compliments, changes: Subtitles listed included dietary, nursing, housekeeping, activities, maintenance and admission. Staff attendee listed as Activities, who attended all 12 meetings occurring in the year 2018. No meeting was held in January 2019. The documents from 1/7/2018 through 12/19/2018 did not indicate a follow up and/or responses from concerns identified in previous meetings. | F 565 | It is the policy of OCR to address resident concerns in a timely fashion. The resident concerns had been addressed but not placed in a written report back to the resident council. The facility will respond in writing during the resident council meeting on the previous concerns. Audits will be done by the NHA or designee monthly x 3 months and findings will be reported to the QAPI meeting.<br><br>Staff have been educated at the all staff inservice on expectations of resident council concerns and the need to report in writing to the residents at the next resident council meeting.<br><br>The NHA/designee will audit monthly council minutes and timely staff responses to concerns in writing and that they are reviewed timely. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 8 | F 565 | | |

Review of the Resident Council Report dated 2/15/18, identified a complaint about scalloped potatoes needing to be cooked longer and a request to make the potatoes thicker. No response was idenfied on March meeting minutes.

Review of the Resident Council Report dated 4/26/18, indicated complaints about the chicken chow mien they requested. Instead of chicken they were served beef chow mien and they felt they were getting too much canned fruit and indicated that watermelon and cantaloupe would be nice to have in place of the canned fruit. The report further indicated the scalloped potatoes were too runny or too soupy and would sometimes like stuffing in place of potatoes. The May meeting minutes did not have a response to the above complaint.

Review of the Resident Council Report dated 8/23/18 indicated stuffing was requested many resident council meetings ago and resident stated that they never received any stuffing.

Review of the Resident Council Report dated 10/25/18, indicated the fall/winter menus were "crappy menus." The report indicated residents voiced dislike for the new cook and wanted her gone. The report further indicated potatoes one night were cooked wrong and they threw them away. Everything is undercooked and cold. Many other complaints regarding the cook were listed. A request was made to change up the order that food was received as certain residents always get their meals first and were done eating by the time the rest of the residents get their food. The report included that the matters were discussed with the staff and dealt with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 9 | F 565 | | |

appropriately.

Review of the Resident Council Report dated 11/15/18, indicated complaints regarding the serving order, which was still the same and they just didn't think it was fair that the same tables kept getting served first. They also asked for less peaches and different fruit. The residents were told the complaints would be addressed.

Review of the Resident Council Report dated 12/19/18, indicated the residents asked to a put a request in to get rid of canned peaches and pears in the kitchen. They stated that they were given them too often.

During a resident council meeting completed by the survey team on 2/11/19, 3:00 p.m., R8 indicated the only response she had gotten back in regard to canned peaches and pears was that the state told the facility what they had to do with the fruits and vegetables. R8 further indicated that the order for being served their meals had not been addressed or fixed, their soups were still cold and they just don't listen to the residents at all. R8 further indicated the facility needed to be open and listen to the residents and stated "we are the consumer and we need to be taken seriously and talked to openly by those caring for us." R4 indicated that administration at the facility was quick to judge. A concern brought forward from a resident next to her room and then herself to the DON regarding bugs biting people was responded to by saying you must be scratching yourself. R4 further indicated the real issue never got addressed and the weather eventually took care of the bugs.

Review of the facility grievance log for the year

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 10 | F 565 | | |

2018, indicated five complaints were received in January, none identified for February, one complaint in March and one complaint for April. The rest of the log for May, June July, August, September, October, November, December and January were blank. The grievance log included the name of person filing the complaint, complaints received by and date, date concern was given to department head, date follow up occurred and logged and resolution occurred or follow up continued.

During interview on 2/12/19, at 1:13 p.m., the administrator stated they had not had any grievances filed in quite awhile. When questioned whether staff were completing the grievance forms if verbally given, the administrator responded "sometimes we do but not always. I'm guessing we should be doing that." The administrator further indicated the resident council meetings were not written as a grievance, a response was not always given and responses were not always shared at the next resident council meeting. The administrator stated the activities director who attended the resident council meeting was no longer employed and they had not had a meeting since December 2018.

Review of policy titled "Grievance Policy" included:
-The primary purpose of this facility's Grievance Policy is to assure that each resident has the right to voice grievances to the facility or governing agency without fear of discrimination or retaliation, and to ensure the facility makes prompt efforts to resolve grievances.
-The facility will promote the grievance process throughout the organization.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 11<br>-The facility will provide an ongoing system for monitoring and trending grievances and complaints.<br>-Voice grievances - Not limited to formal, written grievance process but may include a residents verbalized complaint to staff.<br>-Prompt effort to resolve - includes facility acknowledgement of complaint/grievances and actively working toward resolution of that complaint/grievance. | F 565 | | |
| F 568 SS=D | Accounting and Records of Personal Funds<br>CFR(s): 483.10(f)(10)(iii)<br><br>§483.10(f)(10)(iii) Accounting and Records.<br>(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br>(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br>(C)The individual financial record must be available to the resident through quarterly statements and upon request.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide a quarterly statement for a resident personal fund account for 1 of 1 resident (R4) reviewed for personal funds.<br><br>Findings include:<br><br>During an interview on 2/10/19, at 3:05 p.m. R4 stated she had not received a quarterly statement from the facility. | F 568 | It is the policy of OCR to provide Quarterly Statements for personal funds. R4 was immediately upon noting with a quarterly statement for her personal fund account. An audit was conducted to ensure all residents who utilize the personal fund account received statements. The personal funds policy was reviewed with the Housing Manager. The NHA or designee will audit the | 2/15/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 568 | Continued From page 12<br><br>R4's admission Minimum Data Set assessment dated 11/19/18 indicated R4 was cognitively intact.<br><br>During an interview on 2/12/19, at 1:57 p.m. the housing manager (HM) stated the last quarterly statements were mailed out on 12/14/18. The HM verified R4 had a personal funds account with the facility. The HM stated she over looked sending out a quarterly statement to R4, probably because she had not used any of the money. The HM stated the statements were to be sent out on a quarterly basis and verified R4 should have received a quarterly statement on 12/14/18.<br><br>During an interview on 2/12/19, at 2:08 p.m. the administrator stated she expected statements for personal funds accounts to be sent out on a quarterly basis.<br><br>The Resident Trust Fund Policy revised 8/2018 included, "The business office will send quarterly statements to the designated party." | F 568 | personal funds account quarterly x 1 years. Findings will be shared at the QAPI meeting. | |
| F 574 SS=C | Required Notices and Contact Information<br>CFR(s): 483.10(g)(4)(i)-(vi)<br><br>§483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:<br>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -<br>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;<br>(B) A description of the requirements and | F 574 | | 2/15/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 574 | Continued From page 13 | F 574 | | |

procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.
(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
(iii) Information regarding Medicare and Medicaid eligibility and coverage;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 574 | Continued From page 14<br>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;<br>(v) Contact information for the Medicaid Fraud Control Unit; and<br>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to post current contact information of all pertinent State agencies and advocacy groups for residents and/or resident representatives within view. This had the potential to affect all 19 residents currently residing in the facility.<br><br>Findings include:<br><br>An observation on 2/10/19, at 4:07 p.m., the facility bulletin boards located off the main hallway by staff restrooms, indicated information for State agencies and advocacy groups was posted at a five feet five inches from the floor, inside an enclosed bulletin board. The Grievance Policy was located on the opposite side of hallway on an open bulletin board at the same height with one grievance form posted below the policy.<br><br>On 2/11/19, at 3:30 p.m., a resident council meeting was held with 5 residents (R2, R3, R7, | F 574 | The facility lowered the postings to 3 feet at the time of notification. The facility will remind the residents at the monthly council meetings where the items are posted. All new admissions are made aware of the postings upon admit. The NHA or designee will monitor monthly x 3 months to ensure placement is adequate. Findings will be shared at the QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 574 | Continued From page 15<br>R14 and R18), four of which required the use of a wheel chair. Residents in attendance were not aware of or how to contact state agencies and advocacy groups for residents. Residents were not aware of any posting of this information present in the building.<br><br>During interview and observation on 2/12/19, at 10:57 a.m., the director of nursing (DON) identified where the State agencies and grievance policy was located. When questioned if she believed residents could read it posted at the current height, she stated "no probably not."<br><br>During interview and observation on 2/12/19, at 1:44 p.m., the administrator identified where the grievance policy and state agencies listings were located. When questioned whether she felt residents could see it at the current height she stated "probably not" and lowered the grievance policy to wheelchair height at approximately 3 feet height. The state agencies contact information at the same height was enclosed in a secured bulletin board and was not able to be moved lower at that time.<br><br>During observation on 2/14/19, at 8:28 a.m., the state agencies and advocacy groups information had been lowered to approximately 3 feet height level. | F 574 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged | F 610 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 610 | Continued From page 16<br>violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to conduct a thorough investigation of an allegation of abuse for 1 of 1 resident (R10) who identified verbal threats.<br><br>Findings include:<br><br>R10's face sheet printed 2/13/19, identified an admission date of 9/14/18. The Problem List printed 2/13/19, included diagnoses of abuse, maltreatment adult suspected, obesity, stroke, wheelchair dependence, and autoimmune disorder.<br><br>R10's quarterly Minimum Data Set dated 12/19/18, indicated R10 was cognitively intact, and required extensive assistance with dressing, bed mobility, toilet use and personal hygiene.<br><br>A history and physical note dated 9/11/18 from hospital internal medicine identified R10 arrived via emergency medical services accompanied by her county social worker. R10 notified adult protective services after her family member (FM) | F 610 | It is the policy of OCR to investigate all allegations of abuse and file VA reports. All future allegations will include statements from all staff who may have information regarding allegations of abuse. The abuse policy will be reviewed by all staff at the scheduled inservice on 3/19/19.<br><br>The allegation of abuse reported by resident's misappropriation of funds has been investigated and the online report completed and law enforcement was notified.<br><br>The Administrator/DON have updated and reviewed the policy for reviewing, investigating, and reporting to the appropriate authorities. All staff were educated on the abuse policy and the importance of reporting allegations of abuse immediately and overall review of abuse prevention. Random audits will be completed by the Administrator/DON or | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 610 | Continued From page 17<br>-F, FM-G, FM-H, whom she relied upon for care, stopped coming to her home. R10 reported that she did not feel safe at home due to her FM-F's verbal and physical abuse. There are allegations that family is taking her benefits and spending them improperly.<br><br>Nursing Home Incident Reporting form submitted by the facility on 2/7/19, by the director of nursing (DON) indicated the following: the resident indicated that sometime between 1/27/19 - 2/2/19 "last week" her FM-H had been calling and messaging her with threatening statements, through various "fake" accounts on social media, that FM-H created with Facebook. Resident had noticed different calls coming through her FB messenger app and answered the first one in which the caller stated, "You are worth more dead, than alive". The resident could tell by the tone of voice it was FM-H. Resident hung up and blocked and deleted several of the made-up accounts that FM-H had created to try to defer FM-H. Shortly after receiving the first call, another one came in shortly after that on FB messenger again. This time when the resident answered the phone the caller, who was also identified as FM-H stated, " Die b...., die. " This is when the resident had informed the night shift staff if FM-H was to come to visit her, not to confront him and to allow him to enter her room. Resident stated that FM-H was back with his ex-girlfriend, mother of his children, she is a known drug addict and "gets" FM-H into drugs and trouble. Resident went on to describe the ex-girlfriend's drugs of choice and indicated that was what they were consuming and made FM-H an entirely different person. This writer asked the resident if she believed FM-H would come to the facility and act on these threats, and this writer asked if the resident was | F 610 | designee to ensure residents fell free to report to staff any allegations of abuse, neglect, exploitation or mistreatment. The DON is responsible to investigate all allegations of abuse and complete a thorough investigation of each allegation and complete the online reporting as well as reporting to law enforcement as appropriate. All findings will be reviewed at the QAPI meeting.<br><br>The Administrator and/or designee will monitor all allegations of abuse to ensure a thorough investigation has been completed at the time of suspected/reported abuse. All findings will be reviewed at the QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 610 | Continued From page 18 | F 610 | | |

scared or feared for her life. Resident rebutted with, "No, I do not think FM-H would come here and hurt me. FM-H is too consumed with drugs and likes to " run his mouth and sound tough." This writer asked resident if she felt threatened, at winch time she denied and shook her head, " No, not at all."

During interview on 2/13/19, at 8:09 a.m., R10 indicated that FM-H contacted her on Facebook requesting money to which she replied she didn't have any. R10 stated FM-H then said you are worth more dead than you are alive and hung up on her. R10 indicated she was not afraid and stated FM-H has visited her in the past but not since this last contact. R10 further indicated FM-H was currently in jail.

During interview on 2/13/19, at 9:36 a.m., the DON indicated she filed the report to the state agency the same day she became aware of the incident, 2/7/19. The DON further indicated that R10 came to the administrator and herself to tell them about the incident with FM-H. The DON indicated R10 was not fearful but wanted the faciltiy to know.

During interview on 2/13/19, at 10:45 a.m., R10 indicated she thought the staff on duty whom she reported to regarding FM-H was licensed practice nurse (LPN)-B and NA-B. R10 indicated she had told them FM-H was begging for money and called telling me she was worth more dead than alive. R10 indicated that a few of the nurses knew FM-B because they had kids that were friends with him. They know he wouldn't do anything either because they have known him for so long. R10 looked through her phone for exact dates of the allegation, but R10 indicated she had

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OSTRANDER CARE AND REHAB | 305 MINNESOTA STREET OSTRANDER, MN 55961 |

| (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 610 | Continued From page 19<br>deleted those accounts.<br><br>During interview on 2/13/19, at 11:09 a.m., LPN-B indicated R10 came out to the nurses station, last week when she was working and told her FM-H was calling her and messaging her on Facebook wanting R10 to give him money. LPN-B further indicated she was never told by R10 about comments FM-H made. LPN-B was not aware of any of these occurrences besides FM-H wanting money from R10.<br><br>During interview on 2/13/19, at 11:40 a.m., RN-A stated she was talking to R10 said that FM-H didn't care about her, but had never stated he made comments about dying.<br><br>On 2/13/19, at 12:54 p.m., this surveyor verified R10's FM-H was listed on county jail roster as current inmate and was arrested 2/9/19.<br><br>During interview on 2/13/19, at 1:37 p.m., the administrator and DON upon request of their investigation, identified there was no notes of the investigation or conversations that occurred after they were notified of this incident, except what was entered in the state reporting system. The DON indicated she never questioned the staff members who worked the shift in which the event occurred. The faciltiy had not completed a thorough investigation to determine when the event occurred, or if R10's allegation was accurate or creditable. The DON indicated they did post a blue slip at the nurses station regarding ensuring locking of the doors and told staff to notify herself or the administrator immediately if there were any concerns with FM-H. | F 610 | | |
| F 661 | Discharge Summary | F 661 | | 2/15/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 661 SS=D | Continued From page 20<br>CFR(s): 483.21(c)(2)(i)-(iv)<br><br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to complete a summary of the resident stay (recapitulation) for 1 of 1 resident (R19) reviewed for closed record review.<br><br>Findings include: | F 661 | It is the policy of OCR to complete a recapitulation of all residents who discharge from the facility. All residents who discharge from OCR will have a recapitulation completed. Audits will be conducted by the DON or designee for compliance of completing recapitulations. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 661 | Continued From page 21<br>R19's closed medical record Face Sheet indicted and admision date of 11/2/18, following an acute care hospital stay for a partial intestinal obstruction.<br><br>A progress note dated 11/24/18, indicated R19 discharged from the facility to home with no home health services. Review of the medical record revealed there was no evidence of the recapitulation of resident's stay documented.<br><br>During an interview on 2/12/19, at 1:27 p.m. the director of nursing (DON) stated she was unable to find R19's discharge summary in the medical record. The DON stated she would have expected the post-discharge plan of care to be completed and to be a part of the medical record.<br><br>During an interview on 2/12/19, at 2:10 p.m. the administrator stated all residents should have a discharge summary completed upon discharge from the facility.<br><br>The Discharge Planning Policy dated 8/2018 included, " ...a. A discharge summary will be completed upon discharge to include: a. A recapitulation of the residents stay in the facility (diagnosis, course of illness/treatment, therapy, lab, radiology and consultation reports. b. A final summary of resident status. c. Medication reconciliation. d. A post-discharge plan of care developed with the resident and resident representative. i. Location/Agency/Facility where resident will reside. ii. Arrangements for care, medications and services post-discharge. iii. Arrangements for follow up communication post-discharge. | F 661 | Findings will be discussed at the QAPI meetings.<br><br>An audit was conducted for all discharged assessments since survey with 1 resident dc to home and a recapitulation was completed for the resident. All staff have been educated at the staff inservice on the policy of completing recapitulations for all resident discharges. All discharge residents will be audited monthly by the DON/designee and findings will be reported to the QAPI meeting. | |
| F 688 | Increase/Prevent Decrease in ROM/Mobility | F 688 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 SS=D | Continued From page 22<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide services to maintain range of motion (ROM) of upper extremities for 1 of 1 resident (R5) reviewed for ROM.<br><br>Findings include:<br><br>R5's current diagnoses according to the undated Face Sheet included: polyosteoarthritis unspecified (joint pain and stiffness) and major depressive disorder.<br><br>R5's Functional Mobility Assessment dated 11/20/18 identified functional limitation in ROM upper extremity (shoulder, elbow, wrist, hand) impairment on both sides. | F 688 | It is the policy of OCR that ROM services are provided to residents. R5 was evaluated by therapy during the survey and recommended adaptive equipment for R%'s hands. This equipment was provided by the facility. All residents will be assessed quarterly to coincide with the MDS schedule and as needed. The ROM policy will be reviewed at the scheduled inservice on 3/19/19, All residents will be referred to therapy if any change is noted in ROM. The DON or designee will be responsible for compliance. Findings of the audits will be reviewed at the QAPI meeting.<br><br>All residents have been reassessed by the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 | Continued From page 23<br><br>R5's quarterly Minimum Data Set (MDS) assessment dated 11/22/18, indicated R5 required extensive assistance of staff with bed mobility, locomotion, dressing, grooming, eating and had upper extremity impairment on both sides.<br><br>Review of the physical therapy (PT) plan of care dated 4/25/17, identified R5 had limited ROM in both hands<br>R5's comprehensive care plan, last revised 12/3/18, identified an alteration in self-care deficit. The care plan identified R5 required extensive assist of one staff with grooming, extensive assist of two staff for dressing, bathing tasks, and toileting. The care plan did not address R5's upper extremity impairment and limited ROM in R5's hands. . Review of the occupational therapy (OT) plan of care dated 2/11/19, identified R5 had right and left hand contractures. OT recommended R5 would benefit from bilateral resting hand orthotic and passive ROM program to prevent further ROM contractures in bilateral upper extremities.<br><br>During an observation and interview on 2/10/19, at 4:35 p.m. R5 was observed to have her hands in a clenched fist position and was unable to straighten out her hands, upon request. R5 stated staff did not do any exercises with her hands.<br><br>R5 was observed on 2/12/19, at 2:25 p.m. resting in her bed wearing headphones, hands were in clenched fist position.<br><br>R5 was observed on 2/14/19, at 1:17 p.m. being pushed back to her room in her wheelchair and had rolled wash cloths placed in both of her | F 688 | DON and are receiving proper services. Residents have been referred to therapy as needed.<br><br>Random audits completed by the DON or designee to ensure ROM assessments have been completed and residents have proper services. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 | Continued From page 24 | F 688 | | |

hands.

During an interview on 2/11/19, at 2:42 p.m. nursing assistant (NA)-F stated she did not do any exercises with R5's hands. NA-F stated R5 could hold the cups at meals by herself. NA-F stated when she put lotion on R5's hands she was not able to fully open them.

During an interview on 2/11/19, at 2:46 p.m. nursing assistant (NA)-B stated she did not do any exercises with R5's hands. NA-B stated R5 was able to use a soft call light, but sometimes would just holler (when she needed help).

During an interview on 2/11/19, at 3:36 p.m. licensed practical nurse (LPN)-B stated R5's hands were," kind of contracted up" and stated we had to get her up for therapy. LPN-B stated I have noticed that they (R5's hands) were contracted and stated we have not been doing any exercises with her hands. LPN-B stated she thought a couple of years ago they used wash clothes in her hands but she refused them as she did not want them in her hands.

During an interview on 2/13/19, at 8:20 a.m. nursing assistant (NA)-A stated R5 can pick up her cup, drink her drinks and can use her soft call light. NA-A stated R5 was not able to fully open her hands. NA-A stated she tried to do ROM when washing R5's hands and putting on lotion. NA-A stated R5 would state, "Don't do that that hurts." NA-A stated I have seen rags rolled up in hands or splints for other residents but have not seen those used for R5.

During an interview on 2/13/19, at 10:21 a.m. nursing assistant (NA)-H stated R5 did not use

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 | Continued From page 25 | F 688 | | |

her hands a whole lot, and stated staff fed her and sometimes she would hold her cup. NA-H stated staff did not do any exercises with R5's hands. NA-H stated she had worked here since the end of November and R5's hands has been like this since then.

During an interview on 2/11/19, at 12:11 p.m. the director of nursing (DON) stated at mealtime R5 could hold a glass. The DON stated she did not think staff were doing any exercises with her. The DON stated she was not aware R5's hands did not open fully. The DON verified R5 did not have a ROM program in place.

During an interview on 2/12/19, at 9:47 a.m. the DON stated R5 had an OT screen yesterday and the OT recommended hand splints to order. The DON stated if staff noticed a change (in a resident), they would update their charge nurse, the nurse would communicate with therapy, and then therapy would get an order from the doctor to evaluate and treat. The DON stated she was not aware R5 had any limitations in her hands.

During an interview on 2/12/19, at 11:11 a.m. the administrator stated the DON completed the ROM assessments for the residents and stated she input the information into the MDS assessments. The administrator verified the ROM assessment completed on 11/20/18, by the DON identified R5 functional limitation in ROM upper extremity impairment on both sides.

During a telephone interview on 2/12/19, at 1:08 p.m. OT-A stated she had not worked with R5's hand contractures prior to 2/11/19 and stated R5 had not been referred to therapy for anything to do with her hands from what she could

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 | Continued From page 26<br>remember. OT-A stated she had worked at Ostrander Care and Rehab for a couple of years now. OT-A stated she evaluated R5 yesterday (2/11/19) and took measurements of her hands. OT-A stated R5 had osteoarthritis of her hands and stated this could be a contributor to her limited ROM. OT-A stated she took measurements of R5's hands and I have found in both hands she was limited in her joints, the main first knuckle. OT-A stated I thought a good preventative measure was to order bilateral resting hand orthotics for R5 to wear at nighttime. OT-A stated she also recommended providing passive ROM to her finger joints. OT-A stated she would pick her up to order the orthotics and to complete passive ROM to her fingers, wrist down to her fingers to make sure she can tolerate the passive ROM and it is not painful for her. OT-A stated in this facility therapy did not screen residents for any declines. OT-A stated they relied on communication from nursing with any changes. OT-A stated if staff noticed any decline in function, therapy would get a doctor order to assess the decline in the resident. OT-A stated she was unable to determine if R5's contractures in her hands were worse as therapy had not worked with R5 for hand contractures in the past.<br><br>A policy was requested for ROM services and was not provided. | F 688 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical | F 690 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 27<br>condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were followed related to the care of catheter drainage bags for 2 of 2 residents (R10, R112) observed with an indwelling catheter.<br><br>Findings include: | F 690 | It is the policy of OCR to provide infection control measures to residents who have catheter drainage bags. R10 catheter has been evaluated and discontinued per the residents physician. R112 no longer resides in the facility. The policy on care of indwelling catheter will be reviewed at the scheduled staff meeting on 3/19/19. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 28<br><br>R10's Problem List form dated 11/23/18, indicated diagnoses which included stroke, wheelchair dependence, overactive bladder, urinary tract infection, autoimmune disorder, and neurogenic bladder.<br><br>R10's quarterly Minimum Data Set (MDS) dated 12/19/18, indicated R10 was cognitively intact, required extensive assistance with dressing, bed mobility, toilet use and personal hygiene and was frequently incontinent of urine.<br>R10's current care plan dated 9/28/18, indicated a neurogenic bladder and incomplete voiding manifested by cloudy, foul smelling urine and incontinence.<br><br>During observation and interview 2/10/19, at 1:26 p.m., R10 was sitting up in bed and indicated she currently had a urinary tract infection and had a urinary catheter related to not being able to void. The urinary catheter bag was uncovered and the spout for emptying urine was making contact with the foot pedal platform the bag was lying on. The catheter tubing extending from the bed to the catheter bag looped downward touching the floor, looping back up to the catheter bag. The urine in the tubing was thick, hazy, dark yellow to brown with sediment present in the tubing.<br><br>R10's Provider Orders printed 2/10/19, at 6:50 p.m. indicated R10 started Macrobid 100 mg capsule by mouth twice a day for 7 days for urinary tract infection.<br><br>During observation on 2/12/19, at 10:45 a.m., R10 was sitting up in bed with the uncovered catheter bag laying on foot plate with bag spout making contact with foot plate. The urine in the | F 690 | The DON or designee will complete random audits to ensure infection control practices are followed by staff. Findings will be reviewed at the QAPI meeting.<br><br>Random audits of residents who reside in the facility that have catheters will be monitored for appropriate covering of the catheter bag and they are properly placed to prevent spread of infection. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 29 | F 690 | | |

tubing was hazy, dark yellow to brown with sediment present in the tubing. The tubing extended from the bed down to the floor and back up to the catheter bag.

During observation and interview on 2/12/19, at 11:00 a.m., the director of nursing (DON) observed R10's uncovered catheter bag lying on the foot plate of wheelchair. The DON picked the uncovered catheter bag off foot plate of wheelchair and hung it on side of bed requesting R10 to raise the bed until drainage bag was lower than the tubing. The DON then milked the tubing to get thick dark cloudy urine to drain into the bag. The DON confirmed the catheter bag should not be laying on the foot plate of the wheelchair and the bag needed to be lower than the bed to promote drainage.

R112's Problem List of current diagnosis, undated, included urinary tract infection, heart failure, stroke, and decline in functional status.

R112's admission MDS dated 12/24/18, identified R112 had moderately impaired cognition, required extensive assistance of one for transferring, personal hygiene, toileting and bed mobility. R112 was unsteady on her feet, and occasionally incontinent of urine.

During observation on 2/10/19, at 12:51 p.m., R112 is sitting in recliner chair with uncovered catheter bag hanging on garbage can. The tubing ran down side of chair to the floor then looped upwards towards garbage can where catheter bag was hooked. R112's husband stated they put the catheter in before she left the hospital for comfort measures.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 30 | F 690 | | |

During observation at 2/10/19, at 6:50 p.m., R112 remains in a recliner with an uncovered catheter bag hooked to garbage can and tubing extending from R112 in the recliner down to touching the floor and looped upwards to the garbage can.

During observation on 2/11/19, at 12:54 p.m., R112 is sitting in recliner with 8 visitors present. The uncovered catheter bag is hooked to side of garbage can with tubing extending from recliner chair downwards and looping back up to catheter bag.

During interview on 2/12/19, at 10:12 a.m., NA-G indicated it is normal to hang the catheter bag on the waste basket.

During interview on 2/12/19, at 10:45 a.m., the DON confirmed catheter should not be hanging on a garbage can.

During observation on 2/12/19, at 10:29 a.m., R112's catheter bag remains hooked onto garbage can.

During interview on 2/12/19, at 9:21 a.m., nursing assistant (NA)-H indicated catheter care included putting on gloves to empty and measure it, wipe the end of tubing with antiseptic wipes and then put leg bag on. If the plan is to continue drainage to the regular catheter bag, they wipe the end of drainage tube with antiseptic once bag is emptied. NA-H further indicated they do not clean the catheter bags but they change them weekly or when the nurse puts a new bag in the residents room.

A policy on the care of an indwelling catheter was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 31<br>requested. None was provided. | F 690 | | |
| F 790 SS=D | Routine/Emergency Dental Srvcs in SNFs<br>CFR(s): 483.55(a)(1)-(5)<br><br>§483.55 Dental services.<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(a) Skilled Nursing Facilities<br>A facility-<br><br>§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;<br><br>§483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;<br><br>§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;<br><br>§483.55(a)(4) Must if necessary or if requested, assist the resident;<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services location; and<br><br>§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of | F 790 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 790 | Continued From page 32<br>what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 1 residents (R4) reviewed for dental services.<br><br>Findings include:<br><br>During an interview on 2/10/19, at 3:25 p.m. R4 stated, "My teeth need major work." R4 stated she was planning to have her dental needs addressed, but nobody had helped her secure a dental appointment. R4 stated she did not have dental pain and the dental work needed did not affect ability to eat or chew.<br><br>R4's admission Minimum Data Set (MDS) assessment dated 11/19/18 indicated R4 was cognitively intact. The MDS further indicated R4 had no dental concerns.<br><br>R4's care plan printed 2/13/19 did include a dental care plan, and there was no assessment identified in his medical record.<br><br>On 2/12/19, at 12:15 p.m. the administrator stated they were not able to find a dental assessment for R4. The administrator stated last night they had a nurse go through the building and complete dental assessments for all of the residents. The administrator stated she did not look into R4's mouth when she completed the admission MDS for R4 or had talked to R4 about her teeth. The administrator stated she was going | F 790 | It is the policy of OCR to assist residents with securing dental appointments. R4 oral assessment was completed immediately upon reports of dental concerns. R4 has a dental appointment scheduled 3/20/19. The facility will assist with securing appointments as needed by residents. The dental care policy will be reviewed at the scheduled staff inservice on 3/19/19. The DON or designee will be responsible for compliance of oral assessments. Findings will be reviewed at the QAPI meeting.<br><br>All residents have had oral assessments completed and referrals made as appropriate. All new admissions will have oral assessment completed upon admission and quarterly with MDS completion and prn.<br><br>Random audits of oral assessments/referrals will be conducted by the NHA/designee to ensure compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 790 | Continued From page 33<br>by the director of nurse's report of no dental concerns when she completed the MDS. The administrator stated we need to be completing dental assessments on residents upon admission and on a quarterly basis. The administrator verified dental assessments for residents were not being completed. The administrator verified the dental assessment on R4 was completed on 2/11/19, indicated R4 had pain in her teeth and nursing would be arranging for R4 to see a dentist.<br><br>The Dental Care policy dated 8/2018 include, Dental assessment upon admission is done through the initial nursing assessment. Residents with a dental problem may be taken to their dentist's office if they choose. Arrangements for transportation are made with the patient's family. If a resident with a dental problem is unable to go to his dentist, his physician is contacted. Procedure: 1. Nursing staff contacts dentist of patient's choice for consultation. 2. Social services helps to coordinate to find a dentist that will accept medical assistance or family/resident may choose to pay private pay for dental service. 3. Transportation is coordinated between nursing and social services. | F 790 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. | F 880 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 34<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 35<br>contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to have an infection control program that had an ongoing analysis of surveillance data, and use of evidence based surveillance criteria to define infections. This has the potential to affect all 19 residents residing in the facility.<br><br>Findings include:<br><br>During an interview on 2/12/19, at 10:34 a.m., with director of nursing(DON), who was identified as infection preventionist, indicated she uses the infection report log and works monthly with the medical director, looking for trends and patterns of infections. Upon request to view the infection report log along with any trends or patterns, the DON indicated she would look for it and provide me a copy. The DON indicated the McGeer's criteria is used to monitor and define infections. Upon request to view the completed McGeer | F 880 | It is the policy of the facility to establish and maintain an infection prevention & control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. It is the policy of the facility to utilize the McGreers Definitions for Healthcare Associated Infections to evaluate signs and symptoms of infections. Residents who reside in the facility have the potential to be affected by this finding. Nursing staff will be educated and new staff will be provided a copy of the McGreers form to review criteria. If a resident exhibits s/s of infection nurse will complete form and if meets criteria will notify the physician; if not will monitor. The DON or designee will monitor completion | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 36<br>forms, the DON indicated she would look for them and provide copies. The DON indicated they have not had any outbreaks or any residents on isolation over the past year. The DON further indicated they do not post any signs for dignity purposes if someone is on isolation since they are such a small facility everyone knows if there is an infection. The DON further indicated families are aware and notified by phone call if a family member has an infection. The DON indicated she prints out a 24 hour report that indicates if a resident has been diagnosed with an infection. A copy of the infection prevention and control plan was requested and a copy of the "Infection Control Policy - Isolation Process" was received.<br><br>The "Infection Control Policy - Isolation Process" identified:<br>-Every reasonable attempt will be made to prevent the spread of infection at the Care and Rehab-Ostrander. A variety of infection control measures outlines below are used for decreasing the risk of transmission of organisms at the Care and Rehab-Ostrander.<br>-Standard Precautions including handwashing<br>-Protective Eyewear and Nose/Mouth droplet precautions Masks<br>-Patient Care Equipment<br>-Environmental Control<br>-Linen<br>-Contaminated Sharps<br>-Resuscitation<br>-Transmission based precautions including airborne and droplet.<br><br>The facility "Infection Report" was received 2/13/19, along with blank McGeer's criteria forms that included gastrointestinal tract infections, | F 880 | of McGreers form for all residents that are on ATB or showing s/s of infection will have McGreers form filled out correctly and proper notification of infection and provide education as needed.<br><br>The DON or designee will monitor completion of McGreers form weekly for all residents that are on ATB or showing s/s of infection will have McGreers form filled out correctly and proper notification of infection and provide education as needed to ensure that infections are being tracked and trended. The DON will ensure all nursing staff are educated on the use of the McGreers form upon hire and as needed. Findings will be reviewed at the QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 37 | F 880 | | |

respiratory tract infections, skin, soft tissue and mucosal infections, and urinary tract infections. The infection report was reviewed from 2/12/18, to 2/12/19, and included resident, unit, infection date, origin, infection site, lab, pathogen type, treatment, isolation, risk factors, repeat infection and comments section. Signs and symptoms were not present on the spread sheet. Review of the collected data did not identify pathogen type on 9 out of 12 events where lab column identified culture and sensitivity was completed and one comment was present in the comment section. No evidence of evaluation for trends or follow-up activity was present. Twenty one infections were identified throughout the year for 15 residents.

On 2/13/19 at 10:20 a.m., a second request to the DON was made for completed McGeer's criteria forms and infection control surveillance plan.

During interview on 2/13/19, at 1:45 p.m., licensed practical nurse (LPN)-B indicated she was not aware of need to complete McGeer's forms for signs and symptoms of infection and was unaware of where they are located.

On 2/14/19 at 08:29 a.m., the DON provided blank McGeer's criteria forms.

During interview on 2/14/19 at 8:29 a.m., registered nurse (RN)-A indicated he was not aware of McGeer's forms that were to be completed when residents had signs or symptoms of infection. He further indicated he was told to complete a change of condition form.

Policies and Procedures for the facility related to infection prevention provided included:
-Antibiotic Stewardship including use of McGeer's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 38<br>definitions use that would guide physicians and nursing staff to determine if resident symptoms meet criteria for antibiotic treatment.<br>- Nursing staff will fill out and compete the appropriate McGeer's Criteria form with resdient's signs/symptoms, prior to notification of physician to see if symptoms meet criteria for treatment. | F 880 | | |
| F 881 SS=F | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to establish a process for antibiotic review in order to determine appropriate indications, dosage, duration, and trends of antibiotic use and resistance. This had the potential to affect all 19 residents who resided in the facility.<br><br>Findings include:<br><br>During interview with the director of nursing (DON), who was identified as infection prevention, on 2/12/19, at 10:34 a.m., the DON indicated she uses the infection report log and works monthly with the medical director, looking for trends and patterns of infections and antibiotic use. Upon request to view the infection report log | F 881 | It is the policy of the facility to establish and maintain an infection prevention & control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. It is the policy of the facility to utilize the McGreers Definitions for Healthcare Associated Infections to evaluate signs and symptoms of infections. Residents who reside in the facility have the potential to be affected by this finding. Nursing staff will be educated and new staff will be provided a copy of the McGreers form to review criteria. If a | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 881 | Continued From page 39<br>along with any trends or patterns, the DON indicated she would look for it and provide me a copy. The DON indicated the McGeer's criteria is used to monitor and define infections along with appropriate antibiotic use. Upon request to view the completed McGeer's forms, the DON indicated she would look for them and provide copies.<br><br>The facility "Infection Report" was received 2/13/19, along with blank McGeer's criteria forms that included gastrointestinal tract infections, respiratory tract infections, skin, soft tissue and mucosal infections, and urinary tract infections.<br><br>The infection report was reviewed from 2/12/18 to 2/12/19 with report listed in alphabetical order of residents that included, unit, infection date, origin, infection site, lab, pathogen type, treatment, isolation, risk factors, repeat infection and comments section. Signs and symptoms were not present on the spread sheet. Review of the collected data did not identify pathogen type on 9 out of 12 events where lab column identified culture and sensitivity was completed. One comment was present in the comment section that included a culture was growing over 100,000 colonies of gram-negative rods - follow up with culture on 4/30/18. No evidence of evaluation for follow-up activity was present. Four infections were listed as repeat infections with one comment of resident having previous infections like this at home. One urinary tract infection identified 4/12/18 indicated a healthcare acquired infection at this facility with urine completed but no culture, a risk factor of indwelling catheter, treatment of antibiotic and as a repeated infection with no further follow up. | F 881 | resident exhibits s/s of infection nurse will complete form and if meets criteria will notify the physician; if not will monitor. The DON or designee will monitor completion of McGreers form for all residents that are on ATB or showing s/s of infection will have McGreers form filled out correctly and proper notification of infection and provide education as needed.<br><br>The DON or designee will monitor completion of McGreers form weekly for all residents that are on ATB or showing s/s of infection will have McGreers form filled out correctly and proper notification of infection and provide education as needed to ensure that infections are being tracked and trended. The DON will ensure all nursing staff are educated on the use of the McGreers form upon hire and as needed. Findings will be reviewed at the QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 881 | Continued From page 40<br>On 2/13/19, at 10:20 a.m., a second request to the DON was made for completed McGeer's criteria forms along with the infection control surveillance plan.<br><br>On 02/13/19, at 1:45 p.m., interview with licensed practical nurse (LPN)-B indicated she was not aware of need to complete McGeer's forms for signs and symptoms of infection and was unaware of where they are located.<br><br>On 2/14/19. at 08:29 a.m., the DON provided a second copy of blank McGeer's criteria forms.<br><br>During interview on 2/14/19, at 8:29 a.m., registered nurse (RN)-A indicated he was not aware of McGeer's forms that were to be completed when residents had signs or symptoms of infection. RN-A further indicated he was told to complete a change of condition form.<br><br>A policy titled "Antibiotic Stewardship Program" was received that included:<br>-Purpose to ensure the appropriate use of antimicrobials, improve resident outcomes while minimizing unintended consequences of antimicrobial use including toxicity, reduce microbial resistance AND decrease the spread of infections cause by multidrug-resistant organisms.<br>-Procedure: McGeer definitions of infection in long term care facilities will guide physicians and nursing staff to determine if resident symptoms meet the criteria for antibiotic treatment.<br>- Nursing staff will fill out and compete the appropriate McGeer's Criteria form with resident's signs/symptoms, prior to notification of physician to see if symptoms meet criteria for treatment. | F 881 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 881 | Continued From page 41<br>-Update the physician with the current signs/symptoms, identifying whether the criteria for treatment was met or not met.<br>-Residents will not be treated with antibiotics on the basis of a culture results if there are no clinical signs or symptoms supporting an infection.<br>-The infection preventionist/designee will review antibiotic orders for adherence to the guidelines. | F 881 | | |
| F 919 SS=D | Resident Call System<br>CFR(s): 483.90(g)(2)<br><br>§483.90(g) Resident Call System<br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.<br><br>§483.90(g)(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and documentation review, the facility failed to ensure resident call lights were maintained and functioning for 1 of 1 residents (R17) reviewed during the survey.<br><br>Findings include:<br><br>R17's admission Minimal Data Set (MDS) dated 1/14/19, identified R17 had severely impaired cognition and required one-person physical assist with dressing, toileting, and personal hygiene.<br><br>During interview on 2/10/19, at 2:16 p.m., R17 indicated she has had a few falls since her | F 919 | It is the policy of OCR to have working call lights in all residents rooms. Call light in R17 room has been repaired. All call lights have been checked to ensure in proper working order. Call light policy will reviewed at the staff inservice on 3/19/19. Work orders will be completed by staff and provided to maintenance for repair. Maintenance will report to NHA/DON at time of issue so that they are aware of repairs needed. Findings will be reviewed at the QAPI meeting.<br><br>Call lights will be audited monthly x 3 months to ensure all are in proper working | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 919 | Continued From page 42<br>admission to the facility with the last fall occurring last weekend which resulted in emergency department visit. R17 indicated they scanned her head and x-rayed her hip and "everything turned out okay."<br><br>During an observation and interview on 2/10/19, at 2:42 p.m., R17's call light did not illuminate outside the room. Nursing assistant (NA)-C answered the call light stating "I know it is R17's call light because hers is the only one not working." R17's call light would beep, but did not illuminate outside the room or on the nurses station call board as confirmed by NA-C. NA-C indicated it quit working before R17 moved into the room. NA-C was unsure if the nonfunctioning call light had been reported to maintenance.<br><br>During interview on 2/10/19, at 3:02 p.m., licensed practice nurse (LPN)-A indicated they were aware the call light was not functioning appropriately and that a part is currently on order for repair.<br><br>During interview on 2/11/19, at 10:30 a.m., R17 indicated she had spoken to the director of nursing (DON) requesting to move to another room.<br><br>During observation on 2/11/19, at 11:15 a.m., R17 moved to another room. Maintenance-A was in the room attempting to repair the call light.<br><br>During observation and interview on 2/13/19, at 8:40 a.m., NA- A indicated the call light was still not working in room 107 and she was unaware if parts were on order. Room 107 was vacant.<br><br>During observation and interview on 2/14/19, at | F 919 | order and no repairs are needed. Findings will be reviewed at QAPI | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 919 | Continued From page 43 | F 919 | | |

8:32 a.m., NA-H indicated a resident was admitted into room 107 yesterday. NA-H turned on call light, and confirmed no light illuminated outside the room or at the nurses station. NA-H indicated she thought it was fixed but "I guess not."

During interview on 2/14/19, at 8:41 a.m., maintenance-A indicated he replaced out the underhalf and the bulbs, which did not repair the call light illumination. Maintenance-A then tested the wires inside and stated he needs to pull new wires to fix the problem. Maintenance-A further indicated he has not had a chance to let anyone know of required repairs at this time.

During interview 2/14/19, at 9:10 a.m., the administrator indicated she and the DON were not aware the call light was not working in room 107 and they did admit a resident into that room yesterday. The administrator further indicated upon notification this morning regarding the call light not illuminating, the resident was given a loud bell to ring until they can move the resident to another room.

A Call Light Policy was requested but not supplied.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/11/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET**<br>**OSTRANDER, MN 55961** |

| (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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE 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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Ostrander Care & Rehab) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES<br>( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St Paul, MN 55101-5145, or<br><br>By email to:<br>fm.hc.Inspections@state.mn.us | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/18/2019 |

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 |
|---|---|---|---|
| | 245464 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/11/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET**<br>**OSTRANDER, MN 55961** |

| (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 |
|---|---|---|---|---|
| K 000 | Continued From page 1<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>(Ostrander Care & Rehab) is a 1 1/2-story building with a partial basement. The original building was constructed in 1968 and was determined to be of Type II(222) construction and meets the construction type allowed for existing buildings.<br><br>The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 32 beds and had a census of 19 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 223 SS=F | Doors with Self-Closing Devices<br>CFR(s): NFPA 101<br><br>Doors with Self-Closing Devices<br>Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous | K 223 | | 2/12/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/11/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET**<br>**OSTRANDER, MN 55961** |

| (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 |
|---|---|---|---|---|
| K 223 | Continued From page 2<br>area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:<br>* Required manual fire alarm system; and<br>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br>* Automatic sprinkler system, if installed; and<br>* Loss of power.<br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 )<br><br>This deficient practice could affect the safety of all ( 19 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 01:00 PM on 02/11/2019, observations and staff interview revealed the following:<br><br>During walk-through of the facility observed that the exit door in Wing 100 did not close and self-latch properly upon testing.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 223 | It is the policy of OCR to keep all self closing doors in proper working order. The door on the 100 Wing was cleared from a build up of ice/snow and the door closes properly. The Maintenance Director will monitor monthly to ensure self closing doors close and latch properly. | |
| K 353 SS=F | Sprinkler System - Maintenance and Testing CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are | K 353 | | 3/26/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/11/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET**<br>**OSTRANDER, MN 55961** |

| (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 |
|---|---|---|---|---|
| K 353 | Continued From page 3<br>inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 9.7.5, 9.7.7, 9.7.8, and NFPA 25 )<br><br>This deficient practice could affect the safety of all ( 19 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 01:00 PM on 02/11/2019, observations, staff interview, and documentation reviewed revealed the following:<br><br>During walk-through of the facility observed the fusible link on the linen chute door was covered with paint<br><br>During documentation review - no records were provided to confirm that the Facility is conducting quarterly inspections of the fire sprinkler system | K 353 | It is the practice of OCR to ensure that the fusable link is maintained on the laundry chute. The fusable link has been ordered and will be replaced upon arrival by 3/26/2019.<br><br>It is the policy of OCR to maintain quarterly inspections of the fire system. PerMar has been contacted and will conduct the quarterly inspection of the fire system.<br><br>It is the responsibility of the Maintenance Director to ensure that quarterly inspections are accurate and that the fusable link is maintained properly. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/11/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET**<br>**OSTRANDER, MN 55961** |

| (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 |
|---|---|---|---|---|
| K 353 | Continued From page 4<br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 353 | | |
| K 511 SS=F | Utilities - Gas and Electric<br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2, NFPA 70 )<br><br>This deficient practice could affect the safety of all ( 19 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 01:00 PM on 02/11/2019, observations and staff interview revealed the following:<br><br>During walk-through of the facility observed unsecured electrical panels in the resident corridors<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of | K 511 | It is the policy of OCR to maintain secured electrical panels. The maintenance director installed locks on the electrical panels to secure the panels. The maintenance director is responsible to ensure the electrical panels are in proper working order. | 2/22/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/11/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET**<br>**OSTRANDER, MN 55961** |

| (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 |
|---|---|---|---|---|
| K 511 | Continued From page 5<br>discovery. | K 511 | | |
| K 914 SS=F | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 6.3.4 (NFPA 99) )<br><br>This deficient practice could affect the safety of all ( 19 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 01:00 PM on 02/11/2019, observation and documentation | K 914 | It is the policy of OCR to monitor and maintain electrical receptacles inaccordance with the regulations. A policy and monthly checklist was developed and updated and placed in the Life Safety Code Documentation Manual. It will be reviewed and updated as needed. The Maintenance Director is responsible to monitor monthly and repair as needed. | 3/14/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **02/11/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 |
|---|---|---|---|---|
| K 914 | Continued From page 6<br>reviewed revealed the following:<br><br>During documentation review - no records were provided to confirm that the Facility has completed their electrical receptacle testing.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 914 | | |
| K 918 SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and | K 918 | | 3/22/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/11/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET**<br>**OSTRANDER, MN 55961** |

| (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 |
|---|---|---|---|---|
| K 918 | Continued From page 7<br>readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) )<br><br>This deficient practice could affect the safety of all ( 19 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 01:00 PM on 02/11/2019, observations and staff interview revealed the following:<br><br>During walk-through of the facility observed no remote emergency stop ( E-stop ) for the emergency generator<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 918 | The facility has contacted an electrician to install the externally mounted E-stop to the generator. This will be installed by 3/22/2019 per the electrician. The NHA will be responsible to ensure this deficient practice is corrected. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 02/10/19 through 02/14/19, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| E 006 SS=C | Plan Based on All Hazards Risk Assessment<br>CFR(s): 483.73(a)(1)-(2)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]<br><br>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*<br><br>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.<br><br>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.<br><br>(2) Include strategies for addressing emergency events identified by the risk assessment.<br><br>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies | E 006 | | 3/26/19 |

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

Electronically Signed | 03/18/2019

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 006 | Continued From page 1<br>that would affect the hospice's ability to provide care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to comprehensively develop emergency preparedness policies and procedures based on the facility completed community risk assessments for all required and facility-identified hazards. This had the potential to affect all 19 residents currently residing in the facility.<br><br>Findings include:<br><br>The facility's Emergency Management Plan, Ostrander Care & Rehab Emergency Operations Plan dated 9/16/2018 identified an undated partially completed "Hazard Vulnerability Analysis." Instructions included evaluate every potential event in each of the three categories of probability, risk, and preparedness and to multiply the ratings for each event in the area of probability, risk and preparedness. The total values, in descending order, will represent the events most in need of organization focus and resources for emergency planning...Probability was completed for each event. Risk was completed on natural events and technological events, but on only 6 of 12 human events identified as low or moderate probability. The preparedness area was completed 1 time out of 37 possibilities. Total scores were not completed.<br><br>Policies and Procedures developed with the emergency operations plan included:<br>-Policy for Emergency Provisions<br>-Procedure for Tracking Residents in the event of an Emergency | E 006 | It is the policy of OCR to update the Hazard Vulnerability Analysis. The Analysis was updated completely and policies were reviewed and updated to include resident elopement, hostage situations, bomb threats & workplace violence. The EOD (emergency operations designee) was educated on the need for annual review and updates to the vulnerable analyses. Administrator and/or EOD will audit this process and findings will be shared at the monthly QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 006 | Continued From page 2<br>-Receiving Facility<br>-Policy for Emergency Preparedness Plan Staff education<br><br>An attachment D was present that included Sheltering-In-Place and Attachment E that identified an Evacuation procedure.<br><br>Areas identified with high total rating scores based on what was completed included: Resident Elopement, Hostage Situation, Bomb threat and Workplace Violence. No policies were present for these identified potential high risk areas.<br><br>During interview on 2/13/19 at 8:20 a.m., the housing director/emergency operations designee (EOD) indicated she was unaware that the hazard vulnerability analysis was not complete or needed to be updated yearly. The EOD further indicated that the current facility hazard vulnerability analysis is from 10/16/15 when they began work on emergency preparedness. The EOD further indicated the policies and procedures that are in the manual are all they have for emergency preparedness and that she has only reviewed the plan on a yearly basis, not the policies or responses that accompany the plan. | E 006 | | |
| E 041 SS=C | Hospital CAH and LTC Emergency Power<br>CFR(s): 483.73(e)<br><br>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. | E 041 | | 3/22/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 3<br><br>§483.73(e), §485.625(e)<br>(e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.<br><br>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1)<br>Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.<br><br>482.15(e)(2), §483.73(e)(2), §485.625(e)(2)<br>Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.<br><br>482.15(e)(3), §483.73(e)(3), §485.625(e)(3)<br>Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.<br><br>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] | E 041 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 4<br>The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.<br>If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.<br>(1) National Fire Protection Association, 1 Batterymarch Park,<br>Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.<br>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.<br>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.<br>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.<br>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.<br>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.<br>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.<br>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.<br>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.<br>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.<br>(x) TIA 12-3 to NFPA 101, issued October 22, 2013. | E 041 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OSTRANDER CARE AND REHAB | 305 MINNESOTA STREET OSTRANDER, MN 55961 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 041 | Continued From page 5<br>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.<br>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview the facility failed to ensure the emergency generator had a remote or externally mounted E-stop (emergency stop) button. This had the potential to affect all 19 residents, staff and visitors of the facility.<br><br>Findings Include:<br><br>On facility tour between 11:30 AM and 03:30 PM on 2/12/2019, observations, and staff interview revealed the following:<br><br>( 1 ) During walk-through of the facility observed the emergency generator did not have a remote or externally mounted E-stop ( emergency stop ) button / switch.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | E 041 | The facility has contracted an electrician to install the externally mounted E-stop to the generator. This will be installed by 3/22/2019 per the electrician. The NHA will be responsible to ensure this deficient practice is corrected. | |
| F 000 | INITIAL COMMENTS<br><br>A standard survey was completed at your facility on February 10 through February 14, 2019 by the Minnesota Department of Health. Ostrander Care and Rehab was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>During the standard survey complaints were also investigated: H5464006C was substantiated and | F 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 6<br>resulted in a deficiency at F610. Complaint H5464005C was unsubstantiated.<br><br>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 be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life | F 565 | | 3/26/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 7<br>in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to timely act upon dietary concerns voiced during resident council for 9 of 9 residents (R14, R8, R3, R10, R15, R12, R2, R19, & R7) identified to have attended resident council meetings.<br><br>Findings include:<br><br>Review of the documents from 1/7/2018 through 12/19/2018 titled Resident Council Report listed concerns, suggestions, complaints, compliments, changes: Subtitles listed included dietary, nursing, housekeeping, activities, maintenance and admission. Staff attendee listed as Activities, who attended all 12 meetings occurring in the year 2018. No meeting was held in January 2019. The documents from 1/7/2018 through 12/19/2018 did not indicate a follow up and/or responses from concerns identified in previous meetings. | F 565 | It is the policy of OCR to address resident concerns in a timely fashion. The resident concerns had been addressed but not placed in a written report back to the resident council. The facility will respond in writing during the resident council meeting on the previous concerns. Audits will be done by the NHA or designee monthly x 3 months and findings will be reported to the QAPI meeting.<br><br>Staff have been educated at the all staff inservice on expectations of resident council concerns and the need to report in writing to the residents at the next resident council meeting.<br><br>The NHA/designee will audit monthly council minutes and timely staff responses to concerns in writing and that they are reviewed timely. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 8 | F 565 | | |

Review of the Resident Council Report dated 2/15/18, identified a complaint about scalloped potatoes needing to be cooked longer and a request to make the potatoes thicker. No response was idenfied on March meeting minutes.

Review of the Resident Council Report dated 4/26/18, indicated complaints about the chicken chow mien they requested. Instead of chicken they were served beef chow mien and they felt they were getting too much canned fruit and indicated that watermelon and cantaloupe would be nice to have in place of the canned fruit. The report further indicated the scalloped potatoes were too runny or too soupy and would sometimes like stuffing in place of potatoes. The May meeting minutes did not have a response to the above complaint.

Review of the Resident Council Report dated 8/23/18 indicated stuffing was requested many resident council meetings ago and resident stated that they never received any stuffing.

Review of the Resident Council Report dated 10/25/18, indicated the fall/winter menus were "crappy menus." The report indicated residents voiced dislike for the new cook and wanted her gone. The report further indicated potatoes one night were cooked wrong and they threw them away. Everything is undercooked and cold. Many other complaints regarding the cook were listed. A request was made to change up the order that food was received as certain residents always get their meals first and were done eating by the time the rest of the residents get their food. The report included that the matters were discussed with the staff and dealt with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 9 | F 565 | | |

appropriately.

Review of the Resident Council Report dated 11/15/18, indicated complaints regarding the serving order, which was still the same and they just didn't think it was fair that the same tables kept getting served first. They also asked for less peaches and different fruit. The residents were told the complaints would be addressed.

Review of the Resident Council Report dated 12/19/18, indicated the residents asked to a put a request in to get rid of canned peaches and pears in the kitchen. They stated that they were given them too often.

During a resident council meeting completed by the survey team on 2/11/19, 3:00 p.m., R8 indicated the only response she had gotten back in regard to canned peaches and pears was that the state told the facility what they had to do with the fruits and vegetables. R8 further indicated that the order for being served their meals had not been addressed or fixed, their soups were still cold and they just don't listen to the residents at all. R8 further indicated the facility needed to be open and listen to the residents and stated "we are the consumer and we need to be taken seriously and talked to openly by those caring for us." R4 indicated that administration at the facility was quick to judge. A concern brought forward from a resident next to her room and then herself to the DON regarding bugs biting people was responded to by saying you must be scratching yourself. R4 further indicated the real issue never got addressed and the weather eventually took care of the bugs.

Review of the facility grievance log for the year

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 10 | F 565 | | |

2018, indicated five complaints were received in January, none identified for February, one complaint in March and one complaint for April. The rest of the log for May, June July, August, September, October, November, December and January were blank. The grievance log included the name of person filing the complaint, complaints received by and date, date concern was given to department head, date follow up occurred and logged and resolution occurred or follow up continued.

During interview on 2/12/19, at 1:13 p.m., the administrator stated they had not had any grievances filed in quite awhile. When questioned whether staff were completing the grievance forms if verbally given, the administrator responded "sometimes we do but not always. I'm guessing we should be doing that." The administrator further indicated the resident council meetings were not written as a grievance, a response was not always given and responses were not always shared at the next resident council meeting. The administrator stated the activities director who attended the resident council meeting was no longer employed and they had not had a meeting since December 2018.

Review of policy titled "Grievance Policy" included:
-The primary purpose of this facility's Grievance Policy is to assure that each resident has the right to voice grievances to the facility or governing agency without fear of discrimination or retaliation, and to ensure the facility makes prompt efforts to resolve grievances.
-The facility will promote the grievance process throughout the organization.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 565 | Continued From page 11<br>-The facility will provide an ongoing system for monitoring and trending grievances and complaints.<br>-Voice grievances - Not limited to formal, written grievance process but may include a residents verbalized complaint to staff.<br>-Prompt effort to resolve - includes facility acknowledgement of complaint/grievances and actively working toward resolution of that complaint/grievance. | F 565 | | |
| F 568 SS=D | Accounting and Records of Personal Funds<br>CFR(s): 483.10(f)(10)(iii)<br><br>§483.10(f)(10)(iii) Accounting and Records.<br>(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br>(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br>(C)The individual financial record must be available to the resident through quarterly statements and upon request.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide a quarterly statement for a resident personal fund account for 1 of 1 resident (R4) reviewed for personal funds.<br><br>Findings include:<br><br>During an interview on 2/10/19, at 3:05 p.m. R4 stated she had not received a quarterly statement from the facility. | F 568 | It is the policy of OCR to provide Quarterly Statements for personal funds. R4 was immediately upon noting with a quarterly statement for her personal fund account. An audit was conducted to ensure all residents who utilize the personal fund account received statements. The personal funds policy was reviewed with the Housing Manager. The NHA or designee will audit the | 2/15/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 568 | Continued From page 12<br><br>R4's admission Minimum Data Set assessment dated 11/19/18 indicated R4 was cognitively intact.<br><br>During an interview on 2/12/19, at 1:57 p.m. the housing manager (HM) stated the last quarterly statements were mailed out on 12/14/18. The HM verified R4 had a personal funds account with the facility. The HM stated she over looked sending out a quarterly statement to R4, probably because she had not used any of the money. The HM stated the statements were to be sent out on a quarterly basis and verified R4 should have received a quarterly statement on 12/14/18.<br><br>During an interview on 2/12/19, at 2:08 p.m. the administrator stated she expected statements for personal funds accounts to be sent out on a quarterly basis.<br><br>The Resident Trust Fund Policy revised 8/2018 included, "The business office will send quarterly statements to the designated party." | F 568 | personal funds account quarterly x 1 years. Findings will be shared at the QAPI meeting. | |
| F 574 SS=C | Required Notices and Contact Information<br>CFR(s): 483.10(g)(4)(i)-(vi)<br><br>§483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:<br>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -<br>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;<br>(B) A description of the requirements and | F 574 | | 2/15/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 574 | Continued From page 13 | F 574 | | |

procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.
(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
(iii) Information regarding Medicare and Medicaid eligibility and coverage;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 574 | Continued From page 14<br>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;<br>(v) Contact information for the Medicaid Fraud Control Unit; and<br>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to post current contact information of all pertinent State agencies and advocacy groups for residents and/or resident representatives within view. This had the potential to affect all 19 residents currently residing in the facility.<br><br>Findings include:<br><br>An observation on 2/10/19, at 4:07 p.m., the facility bulletin boards located off the main hallway by staff restrooms, indicated information for State agencies and advocacy groups was posted at a five feet five inches from the floor, inside an enclosed bulletin board. The Grievance Policy was located on the opposite side of hallway on an open bulletin board at the same height with one grievance form posted below the policy.<br><br>On 2/11/19, at 3:30 p.m., a resident council meeting was held with 5 residents (R2, R3, R7, | F 574 | The facility lowered the postings to 3 feet at the time of notification. The facility will remind the residents at the monthly council meetings where the items are posted. All new admissions are made aware of the postings upon admit. The NHA or designee will monitor monthly x 3 months to ensure placement is adequate. Findings will be shared at the QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 574 | Continued From page 15<br>R14 and R18), four of which required the use of a wheel chair. Residents in attendance were not aware of or how to contact state agencies and advocacy groups for residents. Residents were not aware of any posting of this information present in the building.<br><br>During interview and observation on 2/12/19, at 10:57 a.m., the director of nursing (DON) identified where the State agencies and grievance policy was located. When questioned if she believed residents could read it posted at the current height, she stated "no probably not."<br><br>During interview and observation on 2/12/19, at 1:44 p.m., the administrator identified where the grievance policy and state agencies listings were located. When questioned whether she felt residents could see it at the current height she stated "probably not" and lowered the grievance policy to wheelchair height at approximately 3 feet height. The state agencies contact information at the same height was enclosed in a secured bulletin board and was not able to be moved lower at that time.<br><br>During observation on 2/14/19, at 8:28 a.m., the state agencies and advocacy groups information had been lowered to approximately 3 feet height level. | F 574 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged | F 610 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 610 | Continued From page 16<br>violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to conduct a thorough investigation of an allegation of abuse for 1 of 1 resident (R10) who identified verbal threats.<br><br>Findings include:<br><br>R10's face sheet printed 2/13/19, identified an admission date of 9/14/18. The Problem List printed 2/13/19, included diagnoses of abuse, maltreatment adult suspected, obesity, stroke, wheelchair dependence, and autoimmune disorder.<br><br>R10's quarterly Minimum Data Set dated 12/19/18, indicated R10 was cognitively intact, and required extensive assistance with dressing, bed mobility, toilet use and personal hygiene.<br><br>A history and physical note dated 9/11/18 from hospital internal medicine identified R10 arrived via emergency medical services accompanied by her county social worker. R10 notified adult protective services after her family member (FM) | F 610 | It is the policy of OCR to investigate all allegations of abuse and file VA reports. All future allegations will include statements from all staff who may have information regarding allegations of abuse. The abuse policy will be reviewed by all staff at the scheduled inservice on 3/19/19.<br><br>The allegation of abuse reported by resident's misappropriation of funds has been investigated and the online report completed and law enforcement was notified.<br><br>The Administrator/DON have updated and reviewed the policy for reviewing, investigating, and reporting to the appropriate authorities. All staff were educated on the abuse policy and the importance of reporting allegations of abuse immediately and overall review of abuse prevention. Random audits will be completed by the Administrator/DON or | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 610 | Continued From page 17<br>-F, FM-G, FM-H, whom she relied upon for care, stopped coming to her home. R10 reported that she did not feel safe at home due to her FM-F's verbal and physical abuse. There are allegations that family is taking her benefits and spending them improperly.<br><br>Nursing Home Incident Reporting form submitted by the facility on 2/7/19, by the director of nursing (DON) indicated the following: the resident indicated that sometime between 1/27/19 - 2/2/19 "last week" her FM-H had been calling and messaging her with threatening statements, through various "fake" accounts on social media, that FM-H created with Facebook. Resident had noticed different calls coming through her FB messenger app and answered the first one in which the caller stated, "You are worth more dead, than alive". The resident could tell by the tone of voice it was FM-H. Resident hung up and blocked and deleted several of the made-up accounts that FM-H had created to try to defer FM-H. Shortly after receiving the first call, another one came in shortly after that on FB messenger again. This time when the resident answered the phone the caller, who was also identified as FM-H stated, " Die b...., die. " This is when the resident had informed the night shift staff if FM-H was to come to visit her, not to confront him and to allow him to enter her room. Resident stated that FM-H was back with his ex-girlfriend, mother of his children, she is a known drug addict and "gets" FM-H into drugs and trouble. Resident went on to describe the ex-girlfriend's drugs of choice and indicated that was what they were consuming and made FM-H an entirely different person. This writer asked the resident if she believed FM-H would come to the facility and act on these threats, and this writer asked if the resident was | F 610 | designee to ensure residents fell free to report to staff any allegations of abuse, neglect, exploitation or mistreatment. The DON is responsible to investigate all allegations of abuse and complete a thorough investigation of each allegation and complete the online reporting as well as reporting to law enforcement as appropriate. All findings will be reviewed at the QAPI meeting.<br><br>The Administrator and/or designee will monitor all allegations of abuse to ensure a thorough investigation has been completed at the time of suspected/reported abuse. All findings will be reviewed at the QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 610 | Continued From page 18 | F 610 | | |

scared or feared for her life. Resident rebutted with, "No, I do not think FM-H would come here and hurt me. FM-H is too consumed with drugs and likes to " run his mouth and sound tough." This writer asked resident if she felt threatened, at winch time she denied and shook her head, " No, not at all."

During interview on 2/13/19, at 8:09 a.m., R10 indicated that FM-H contacted her on Facebook requesting money to which she replied she didn't have any. R10 stated FM-H then said you are worth more dead than you are alive and hung up on her. R10 indicated she was not afraid and stated FM-H has visited her in the past but not since this last contact. R10 further indicated FM-H was currently in jail.

During interview on 2/13/19, at 9:36 a.m., the DON indicated she filed the report to the state agency the same day she became aware of the incident, 2/7/19. The DON further indicated that R10 came to the administrator and herself to tell them about the incident with FM-H. The DON indicated R10 was not fearful but wanted the faciltiy to know.

During interview on 2/13/19, at 10:45 a.m., R10 indicated she thought the staff on duty whom she reported to regarding FM-H was licensed practice nurse (LPN)-B and NA-B. R10 indicated she had told them FM-H was begging for money and called telling me she was worth more dead than alive. R10 indicated that a few of the nurses knew FM-B because they had kids that were friends with him. They know he wouldn't do anything either because they have known him for so long. R10 looked through her phone for exact dates of the allegation, but R10 indicated she had

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OSTRANDER CARE AND REHAB | 305 MINNESOTA STREET OSTRANDER, MN 55961 |

| (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 610 | Continued From page 19<br>deleted those accounts.<br><br>During interview on 2/13/19, at 11:09 a.m., LPN-B indicated R10 came out to the nurses station, last week when she was working and told her FM-H was calling her and messaging her on Facebook wanting R10 to give him money. LPN-B further indicated she was never told by R10 about comments FM-H made. LPN-B was not aware of any of these occurrences besides FM-H wanting money from R10.<br><br>During interview on 2/13/19, at 11:40 a.m., RN-A stated she was talking to R10 said that FM-H didn't care about her, but had never stated he made comments about dying.<br><br>On 2/13/19, at 12:54 p.m., this surveyor verified R10's FM-H was listed on county jail roster as current inmate and was arrested 2/9/19.<br><br>During interview on 2/13/19, at 1:37 p.m., the administrator and DON upon request of their investigation, identified there was no notes of the investigation or conversations that occurred after they were notified of this incident, except what was entered in the state reporting system. The DON indicated she never questioned the staff members who worked the shift in which the event occurred. The faciltiy had not completed a thorough investigation to determine when the event occurred, or if R10's allegation was accurate or creditable. The DON indicated they did post a blue slip at the nurses station regarding ensuring locking of the doors and told staff to notify herself or the administrator immediately if there were any concerns with FM-H. | F 610 | | |
| F 661 | Discharge Summary | F 661 | | 2/15/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 661 SS=D | Continued From page 20<br>CFR(s): 483.21(c)(2)(i)-(iv)<br><br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.<br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to complete a summary of the resident stay (recapitulation) for 1 of 1 resident (R19) reviewed for closed record review.<br><br>Findings include: | F 661 | It is the policy of OCR to complete a recapitulation of all residents who discharge from the facility. All residents who discharge from OCR will have a recapitulation completed. Audits will be conducted by the DON or designee for compliance of completing recapitulations. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 661 | Continued From page 21<br>R19's closed medical record Face Sheet indicted and admision date of 11/2/18, following an acute care hospital stay for a partial intestinal obstruction.<br><br>A progress note dated 11/24/18, indicated R19 discharged from the facility to home with no home health services. Review of the medical record revealed there was no evidence of the recapitulation of resident's stay documented.<br><br>During an interview on 2/12/19, at 1:27 p.m. the director of nursing (DON) stated she was unable to find R19's discharge summary in the medical record. The DON stated she would have expected the post-discharge plan of care to be completed and to be a part of the medical record.<br><br>During an interview on 2/12/19, at 2:10 p.m. the administrator stated all residents should have a discharge summary completed upon discharge from the facility.<br><br>The Discharge Planning Policy dated 8/2018 included, " ...a. A discharge summary will be completed upon discharge to include: a. A recapitulation of the residents stay in the facility (diagnosis, course of illness/treatment, therapy, lab, radiology and consultation reports. b. A final summary of resident status. c. Medication reconciliation. d. A post-discharge plan of care developed with the resident and resident representative. i. Location/Agency/Facility where resident will reside. ii. Arrangements for care, medications and services post-discharge. iii. Arrangements for follow up communication post-discharge. | F 661 | Findings will be discussed at the QAPI meetings.<br><br>An audit was conducted for all discharged assessments since survey with 1 resident dc to home and a recapitulation was completed for the resident. All staff have been educated at the staff inservice on the policy of completing recapitulations for all resident discharges. All discharge residents will be audited monthly by the DON/designee and findings will be reported to the QAPI meeting. | |
| F 688 | Increase/Prevent Decrease in ROM/Mobility | F 688 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 SS=D | Continued From page 22<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide services to maintain range of motion (ROM) of upper extremities for 1 of 1 resident (R5) reviewed for ROM.<br><br>Findings include:<br><br>R5's current diagnoses according to the undated Face Sheet included: polyosteoarthritis unspecified (joint pain and stiffness) and major depressive disorder.<br><br>R5's Functional Mobility Assessment dated 11/20/18 identified functional limitation in ROM upper extremity (shoulder, elbow, wrist, hand) impairment on both sides. | F 688 | It is the policy of OCR that ROM services are provided to residents. R5 was evaluated by therapy during the survey and recommended adaptive equipment for R%'s hands. This equipment was provided by the facility. All residents will be assessed quarterly to coincide with the MDS schedule and as needed. The ROM policy will be reviewed at the scheduled inservice on 3/19/19, All residents will be referred to therapy if any change is noted in ROM. The DON or designee will be responsible for compliance. Findings of the audits will be reviewed at the QAPI meeting.<br><br>All residents have been reassessed by the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 | Continued From page 23<br><br>R5's quarterly Minimum Data Set (MDS) assessment dated 11/22/18, indicated R5 required extensive assistance of staff with bed mobility, locomotion, dressing, grooming, eating and had upper extremity impairment on both sides.<br><br>Review of the physical therapy (PT) plan of care dated 4/25/17, identified R5 had limited ROM in both hands<br>R5's comprehensive care plan, last revised 12/3/18, identified an alteration in self-care deficit. The care plan identified R5 required extensive assist of one staff with grooming, extensive assist of two staff for dressing, bathing tasks, and toileting. The care plan did not address R5's upper extremity impairment and limited ROM in R5's hands. . Review of the occupational therapy (OT) plan of care dated 2/11/19, identified R5 had right and left hand contractures. OT recommended R5 would benefit from bilateral resting hand orthotic and passive ROM program to prevent further ROM contractures in bilateral upper extremities.<br><br>During an observation and interview on 2/10/19, at 4:35 p.m. R5 was observed to have her hands in a clenched fist position and was unable to straighten out her hands, upon request. R5 stated staff did not do any exercises with her hands.<br><br>R5 was observed on 2/12/19, at 2:25 p.m. resting in her bed wearing headphones, hands were in clenched fist position.<br><br>R5 was observed on 2/14/19, at 1:17 p.m. being pushed back to her room in her wheelchair and had rolled wash cloths placed in both of her | F 688 | DON and are receiving proper services. Residents have been referred to therapy as needed.<br><br>Random audits completed by the DON or designee to ensure ROM assessments have been completed and residents have proper services. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 | Continued From page 24 | F 688 | | |

hands.

During an interview on 2/11/19, at 2:42 p.m. nursing assistant (NA)-F stated she did not do any exercises with R5's hands. NA-F stated R5 could hold the cups at meals by herself. NA-F stated when she put lotion on R5's hands she was not able to fully open them.

During an interview on 2/11/19, at 2:46 p.m. nursing assistant (NA)-B stated she did not do any exercises with R5's hands. NA-B stated R5 was able to use a soft call light, but sometimes would just holler (when she needed help).

During an interview on 2/11/19, at 3:36 p.m. licensed practical nurse (LPN)-B stated R5's hands were," kind of contracted up" and stated we had to get her up for therapy. LPN-B stated I have noticed that they (R5's hands) were contracted and stated we have not been doing any exercises with her hands. LPN-B stated she thought a couple of years ago they used wash clothes in her hands but she refused them as she did not want them in her hands.

During an interview on 2/13/19, at 8:20 a.m. nursing assistant (NA)-A stated R5 can pick up her cup, drink her drinks and can use her soft call light. NA-A stated R5 was not able to fully open her hands. NA-A stated she tried to do ROM when washing R5's hands and putting on lotion. NA-A stated R5 would state, "Don't do that that hurts." NA-A stated I have seen rags rolled up in hands or splints for other residents but have not seen those used for R5.

During an interview on 2/13/19, at 10:21 a.m. nursing assistant (NA)-H stated R5 did not use

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 | Continued From page 25 | F 688 | | |

her hands a whole lot, and stated staff fed her and sometimes she would hold her cup. NA-H stated staff did not do any exercises with R5's hands. NA-H stated she had worked here since the end of November and R5's hands has been like this since then.

During an interview on 2/11/19, at 12:11 p.m. the director of nursing (DON) stated at mealtime R5 could hold a glass. The DON stated she did not think staff were doing any exercises with her. The DON stated she was not aware R5's hands did not open fully. The DON verified R5 did not have a ROM program in place.

During an interview on 2/12/19, at 9:47 a.m. the DON stated R5 had an OT screen yesterday and the OT recommended hand splints to order. The DON stated if staff noticed a change (in a resident), they would update their charge nurse, the nurse would communicate with therapy, and then therapy would get an order from the doctor to evaluate and treat. The DON stated she was not aware R5 had any limitations in her hands.

During an interview on 2/12/19, at 11:11 a.m. the administrator stated the DON completed the ROM assessments for the residents and stated she input the information into the MDS assessments. The administrator verified the ROM assessment completed on 11/20/18, by the DON identified R5 functional limitation in ROM upper extremity impairment on both sides.

During a telephone interview on 2/12/19, at 1:08 p.m. OT-A stated she had not worked with R5's hand contractures prior to 2/11/19 and stated R5 had not been referred to therapy for anything to do with her hands from what she could

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 688 | Continued From page 26<br>remember. OT-A stated she had worked at Ostrander Care and Rehab for a couple of years now. OT-A stated she evaluated R5 yesterday (2/11/19) and took measurements of her hands. OT-A stated R5 had osteoarthritis of her hands and stated this could be a contributor to her limited ROM. OT-A stated she took measurements of R5's hands and I have found in both hands she was limited in her joints, the main first knuckle. OT-A stated I thought a good preventative measure was to order bilateral resting hand orthotics for R5 to wear at nighttime. OT-A stated she also recommended providing passive ROM to her finger joints. OT-A stated she would pick her up to order the orthotics and to complete passive ROM to her fingers, wrist down to her fingers to make sure she can tolerate the passive ROM and it is not painful for her. OT-A stated in this facility therapy did not screen residents for any declines. OT-A stated they relied on communication from nursing with any changes. OT-A stated if staff noticed any decline in function, therapy would get a doctor order to assess the decline in the resident. OT-A stated she was unable to determine if R5's contractures in her hands were worse as therapy had not worked with R5 for hand contractures in the past.<br><br>A policy was requested for ROM services and was not provided. | F 688 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical | F 690 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 27<br>condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were followed related to the care of catheter drainage bags for 2 of 2 residents (R10, R112) observed with an indwelling catheter.<br><br>Findings include: | F 690 | It is the policy of OCR to provide infection control measures to residents who have catheter drainage bags. R10 catheter has been evaluated and discontinued per the residents physician. R112 no longer resides in the facility. The policy on care of indwelling catheter will be reviewed at the scheduled staff meeting on 3/19/19. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 28<br><br>R10's Problem List form dated 11/23/18, indicated diagnoses which included stroke, wheelchair dependence, overactive bladder, urinary tract infection, autoimmune disorder, and neurogenic bladder.<br><br>R10's quarterly Minimum Data Set (MDS) dated 12/19/18, indicated R10 was cognitively intact, required extensive assistance with dressing, bed mobility, toilet use and personal hygiene and was frequently incontinent of urine.<br>R10's current care plan dated 9/28/18, indicated a neurogenic bladder and incomplete voiding manifested by cloudy, foul smelling urine and incontinence.<br><br>During observation and interview 2/10/19, at 1:26 p.m., R10 was sitting up in bed and indicated she currently had a urinary tract infection and had a urinary catheter related to not being able to void. The urinary catheter bag was uncovered and the spout for emptying urine was making contact with the foot pedal platform the bag was lying on. The catheter tubing extending from the bed to the catheter bag looped downward touching the floor, looping back up to the catheter bag. The urine in the tubing was thick, hazy, dark yellow to brown with sediment present in the tubing.<br><br>R10's Provider Orders printed 2/10/19, at 6:50 p.m. indicated R10 started Macrobid 100 mg capsule by mouth twice a day for 7 days for urinary tract infection.<br><br>During observation on 2/12/19, at 10:45 a.m., R10 was sitting up in bed with the uncovered catheter bag laying on foot plate with bag spout making contact with foot plate. The urine in the | F 690 | The DON or designee will complete random audits to ensure infection control practices are followed by staff. Findings will be reviewed at the QAPI meeting.<br><br>Random audits of residents who reside in the facility that have catheters will be monitored for appropriate covering of the catheter bag and they are properly placed to prevent spread of infection. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 29 | F 690 | | |

tubing was hazy, dark yellow to brown with sediment present in the tubing. The tubing extended from the bed down to the floor and back up to the catheter bag.

During observation and interview on 2/12/19, at 11:00 a.m., the director of nursing (DON) observed R10's uncovered catheter bag lying on the foot plate of wheelchair. The DON picked the uncovered catheter bag off foot plate of wheelchair and hung it on side of bed requesting R10 to raise the bed until drainage bag was lower than the tubing. The DON then milked the tubing to get thick dark cloudy urine to drain into the bag. The DON confirmed the catheter bag should not be laying on the foot plate of the wheelchair and the bag needed to be lower than the bed to promote drainage.

R112's Problem List of current diagnosis, undated, included urinary tract infection, heart failure, stroke, and decline in functional status.

R112's admission MDS dated 12/24/18, identified R112 had moderately impaired cognition, required extensive assistance of one for transferring, personal hygiene, toileting and bed mobility. R112 was unsteady on her feet, and occasionally incontinent of urine.

During observation on 2/10/19, at 12:51 p.m., R112 is sitting in recliner chair with uncovered catheter bag hanging on garbage can. The tubing ran down side of chair to the floor then looped upwards towards garbage can where catheter bag was hooked. R112's husband stated they put the catheter in before she left the hospital for comfort measures.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 30 | F 690 | | |

During observation at 2/10/19, at 6:50 p.m., R112 remains in a recliner with an uncovered catheter bag hooked to garbage can and tubing extending from R112 in the recliner down to touching the floor and looped upwards to the garbage can.

During observation on 2/11/19, at 12:54 p.m., R112 is sitting in recliner with 8 visitors present. The uncovered catheter bag is hooked to side of garbage can with tubing extending from recliner chair downwards and looping back up to catheter bag.

During interview on 2/12/19, at 10:12 a.m., NA-G indicated it is normal to hang the catheter bag on the waste basket.

During interview on 2/12/19, at 10:45 a.m., the DON confirmed catheter should not be hanging on a garbage can.

During observation on 2/12/19, at 10:29 a.m., R112's catheter bag remains hooked onto garbage can.

During interview on 2/12/19, at 9:21 a.m., nursing assistant (NA)-H indicated catheter care included putting on gloves to empty and measure it, wipe the end of tubing with antiseptic wipes and then put leg bag on. If the plan is to continue drainage to the regular catheter bag, they wipe the end of drainage tube with antiseptic once bag is emptied. NA-H further indicated they do not clean the catheter bags but they change them weekly or when the nurse puts a new bag in the residents room.

A policy on the care of an indwelling catheter was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 690 | Continued From page 31<br>requested. None was provided. | F 690 | | |
| F 790 SS=D | Routine/Emergency Dental Srvcs in SNFs<br>CFR(s): 483.55(a)(1)-(5)<br><br>§483.55 Dental services.<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(a) Skilled Nursing Facilities<br>A facility-<br><br>§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;<br><br>§483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;<br><br>§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;<br><br>§483.55(a)(4) Must if necessary or if requested, assist the resident;<br>(i) In making appointments; and<br>(ii) By arranging for transportation to and from the dental services location; and<br><br>§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of | F 790 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 790 | Continued From page 32<br>what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 1 residents (R4) reviewed for dental services.<br><br>Findings include:<br><br>During an interview on 2/10/19, at 3:25 p.m. R4 stated, "My teeth need major work." R4 stated she was planning to have her dental needs addressed, but nobody had helped her secure a dental appointment. R4 stated she did not have dental pain and the dental work needed did not affect ability to eat or chew.<br><br>R4's admission Minimum Data Set (MDS) assessment dated 11/19/18 indicated R4 was cognitively intact. The MDS further indicated R4 had no dental concerns.<br><br>R4's care plan printed 2/13/19 did include a dental care plan, and there was no assessment identified in his medical record.<br><br>On 2/12/19, at 12:15 p.m. the administrator stated they were not able to find a dental assessment for R4. The administrator stated last night they had a nurse go through the building and complete dental assessments for all of the residents. The administrator stated she did not look into R4's mouth when she completed the admission MDS for R4 or had talked to R4 about her teeth. The administrator stated she was going | F 790 | It is the policy of OCR to assist residents with securing dental appointments. R4 oral assessment was completed immediately upon reports of dental concerns. R4 has a dental appointment scheduled 3/20/19. The facility will assist with securing appointments as needed by residents. The dental care policy will be reviewed at the scheduled staff inservice on 3/19/19. The DON or designee will be responsible for compliance of oral assessments. Findings will be reviewed at the QAPI meeting.<br><br>All residents have had oral assessments completed and referrals made as appropriate. All new admissions will have oral assessment completed upon admission and quarterly with MDS completion and prn.<br><br>Random audits of oral assessments/referrals will be conducted by the NHA/designee to ensure compliance. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 790 | Continued From page 33<br>by the director of nurse's report of no dental concerns when she completed the MDS. The administrator stated we need to be completing dental assessments on residents upon admission and on a quarterly basis. The administrator verified dental assessments for residents were not being completed. The administrator verified the dental assessment on R4 was completed on 2/11/19, indicated R4 had pain in her teeth and nursing would be arranging for R4 to see a dentist.<br><br>The Dental Care policy dated 8/2018 include, Dental assessment upon admission is done through the initial nursing assessment. Residents with a dental problem may be taken to their dentist's office if they choose. Arrangements for transportation are made with the patient's family. If a resident with a dental problem is unable to go to his dentist, his physician is contacted. Procedure: 1. Nursing staff contacts dentist of patient's choice for consultation. 2. Social services helps to coordinate to find a dentist that will accept medical assistance or family/resident may choose to pay private pay for dental service. 3. Transportation is coordinated between nursing and social services. | F 790 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. | F 880 | | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 34<br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 35<br>contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to have an infection control program that had an ongoing analysis of surveillance data, and use of evidence based surveillance criteria to define infections. This has the potential to affect all 19 residents residing in the facility.<br><br>Findings include:<br><br>During an interview on 2/12/19, at 10:34 a.m., with director of nursing(DON), who was identified as infection preventionist, indicated she uses the infection report log and works monthly with the medical director, looking for trends and patterns of infections. Upon request to view the infection report log along with any trends or patterns, the DON indicated she would look for it and provide me a copy. The DON indicated the McGeer's criteria is used to monitor and define infections. Upon request to view the completed McGeer | F 880 | It is the policy of the facility to establish and maintain an infection prevention & control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. It is the policy of the facility to utilize the McGreers Definitions for Healthcare Associated Infections to evaluate signs and symptoms of infections. Residents who reside in the facility have the potential to be affected by this finding. Nursing staff will be educated and new staff will be provided a copy of the McGreers form to review criteria. If a resident exhibits s/s of infection nurse will complete form and if meets criteria will notify the physician; if not will monitor. The DON or designee will monitor completion | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 36<br>forms, the DON indicated she would look for them and provide copies. The DON indicated they have not had any outbreaks or any residents on isolation over the past year. The DON further indicated they do not post any signs for dignity purposes if someone is on isolation since they are such a small facility everyone knows if there is an infection. The DON further indicated families are aware and notified by phone call if a family member has an infection. The DON indicated she prints out a 24 hour report that indicates if a resident has been diagnosed with an infection. A copy of the infection prevention and control plan was requested and a copy of the "Infection Control Policy - Isolation Process" was received.<br><br>The "Infection Control Policy - Isolation Process" identified:<br>-Every reasonable attempt will be made to prevent the spread of infection at the Care and Rehab-Ostrander. A variety of infection control measures outlines below are used for decreasing the risk of transmission of organisms at the Care and Rehab-Ostrander.<br>-Standard Precautions including handwashing<br>-Protective Eyewear and Nose/Mouth droplet precautions Masks<br>-Patient Care Equipment<br>-Environmental Control<br>-Linen<br>-Contaminated Sharps<br>-Resuscitation<br>-Transmission based precautions including airborne and droplet.<br><br>The facility "Infection Report" was received 2/13/19, along with blank McGeer's criteria forms that included gastrointestinal tract infections, | F 880 | of McGreers form for all residents that are on ATB or showing s/s of infection will have McGreers form filled out correctly and proper notification of infection and provide education as needed.<br><br>The DON or designee will monitor completion of McGreers form weekly for all residents that are on ATB or showing s/s of infection will have McGreers form filled out correctly and proper notification of infection and provide education as needed to ensure that infections are being tracked and trended. The DON will ensure all nursing staff are educated on the use of the McGreers form upon hire and as needed. Findings will be reviewed at the QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 37 | F 880 | | |

respiratory tract infections, skin, soft tissue and mucosal infections, and urinary tract infections. The infection report was reviewed from 2/12/18, to 2/12/19, and included resident, unit, infection date, origin, infection site, lab, pathogen type, treatment, isolation, risk factors, repeat infection and comments section. Signs and symptoms were not present on the spread sheet. Review of the collected data did not identify pathogen type on 9 out of 12 events where lab column identified culture and sensitivity was completed and one comment was present in the comment section. No evidence of evaluation for trends or follow-up activity was present. Twenty one infections were identified throughout the year for 15 residents.

On 2/13/19 at 10:20 a.m., a second request to the DON was made for completed McGeer's criteria forms and infection control surveillance plan.

During interview on 2/13/19, at 1:45 p.m., licensed practical nurse (LPN)-B indicated she was not aware of need to complete McGeer's forms for signs and symptoms of infection and was unaware of where they are located.

On 2/14/19 at 08:29 a.m., the DON provided blank McGeer's criteria forms.

During interview on 2/14/19 at 8:29 a.m., registered nurse (RN)-A indicated he was not aware of McGeer's forms that were to be completed when residents had signs or symptoms of infection. He further indicated he was told to complete a change of condition form.

Policies and Procedures for the facility related to infection prevention provided included:
-Antibiotic Stewardship including use of McGeer's

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 880 | Continued From page 38<br>definitions use that would guide physicians and nursing staff to determine if resident symptoms meet criteria for antibiotic treatment.<br>- Nursing staff will fill out and compete the appropriate McGeer's Criteria form with resdient's signs/symptoms, prior to notification of physician to see if symptoms meet criteria for treatment. | F 880 | | |
| F 881 SS=F | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to establish a process for antibiotic review in order to determine appropriate indications, dosage, duration, and trends of antibiotic use and resistance. This had the potential to affect all 19 residents who resided in the facility.<br><br>Findings include:<br><br>During interview with the director of nursing (DON), who was identified as infection prevention, on 2/12/19, at 10:34 a.m., the DON indicated she uses the infection report log and works monthly with the medical director, looking for trends and patterns of infections and antibiotic use. Upon request to view the infection report log | F 881 | It is the policy of the facility to establish and maintain an infection prevention & control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. It is the policy of the facility to utilize the McGreers Definitions for Healthcare Associated Infections to evaluate signs and symptoms of infections. Residents who reside in the facility have the potential to be affected by this finding. Nursing staff will be educated and new staff will be provided a copy of the McGreers form to review criteria. If a | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 881 | Continued From page 39<br>along with any trends or patterns, the DON indicated she would look for it and provide me a copy. The DON indicated the McGeer's criteria is used to monitor and define infections along with appropriate antibiotic use. Upon request to view the completed McGeer's forms, the DON indicated she would look for them and provide copies.<br><br>The facility "Infection Report" was received 2/13/19, along with blank McGeer's criteria forms that included gastrointestinal tract infections, respiratory tract infections, skin, soft tissue and mucosal infections, and urinary tract infections.<br><br>The infection report was reviewed from 2/12/18 to 2/12/19 with report listed in alphabetical order of residents that included, unit, infection date, origin, infection site, lab, pathogen type, treatment, isolation, risk factors, repeat infection and comments section. Signs and symptoms were not present on the spread sheet. Review of the collected data did not identify pathogen type on 9 out of 12 events where lab column identified culture and sensitivity was completed. One comment was present in the comment section that included a culture was growing over 100,000 colonies of gram-negative rods - follow up with culture on 4/30/18. No evidence of evaluation for follow-up activity was present. Four infections were listed as repeat infections with one comment of resident having previous infections like this at home. One urinary tract infection identified 4/12/18 indicated a healthcare acquired infection at this facility with urine completed but no culture, a risk factor of indwelling catheter, treatment of antibiotic and as a repeated infection with no further follow up. | F 881 | resident exhibits s/s of infection nurse will complete form and if meets criteria will notify the physician; if not will monitor. The DON or designee will monitor completion of McGreers form for all residents that are on ATB or showing s/s of infection will have McGreers form filled out correctly and proper notification of infection and provide education as needed.<br><br>The DON or designee will monitor completion of McGreers form weekly for all residents that are on ATB or showing s/s of infection will have McGreers form filled out correctly and proper notification of infection and provide education as needed to ensure that infections are being tracked and trended. The DON will ensure all nursing staff are educated on the use of the McGreers form upon hire and as needed. Findings will be reviewed at the QAPI meeting. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 881 | Continued From page 40<br>On 2/13/19, at 10:20 a.m., a second request to the DON was made for completed McGeer's criteria forms along with the infection control surveillance plan.<br><br>On 02/13/19, at 1:45 p.m., interview with licensed practical nurse (LPN)-B indicated she was not aware of need to complete McGeer's forms for signs and symptoms of infection and was unaware of where they are located.<br><br>On 2/14/19. at 08:29 a.m., the DON provided a second copy of blank McGeer's criteria forms.<br><br>During interview on 2/14/19, at 8:29 a.m., registered nurse (RN)-A indicated he was not aware of McGeer's forms that were to be completed when residents had signs or symptoms of infection. RN-A further indicated he was told to complete a change of condition form.<br><br>A policy titled "Antibiotic Stewardship Program" was received that included:<br>-Purpose to ensure the appropriate use of antimicrobials, improve resident outcomes while minimizing unintended consequences of antimicrobial use including toxicity, reduce microbial resistance AND decrease the spread of infections cause by multidrug-resistant organisms.<br>-Procedure: McGeer definitions of infection in long term care facilities will guide physicians and nursing staff to determine if resident symptoms meet the criteria for antibiotic treatment.<br>- Nursing staff will fill out and compete the appropriate McGeer's Criteria form with resident's signs/symptoms, prior to notification of physician to see if symptoms meet criteria for treatment. | F 881 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 881 | Continued From page 41<br>-Update the physician with the current signs/symptoms, identifying whether the criteria for treatment was met or not met.<br>-Residents will not be treated with antibiotics on the basis of a culture results if there are no clinical signs or symptoms supporting an infection.<br>-The infection preventionist/designee will review antibiotic orders for adherence to the guidelines. | F 881 | | |
| F 919 SS=D | Resident Call System<br>CFR(s): 483.90(g)(2)<br><br>§483.90(g) Resident Call System<br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.<br><br>§483.90(g)(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and documentation review, the facility failed to ensure resident call lights were maintained and functioning for 1 of 1 residents (R17) reviewed during the survey.<br><br>Findings include:<br><br>R17's admission Minimal Data Set (MDS) dated 1/14/19, identified R17 had severely impaired cognition and required one-person physical assist with dressing, toileting, and personal hygiene.<br><br>During interview on 2/10/19, at 2:16 p.m., R17 indicated she has had a few falls since her | F 919 | It is the policy of OCR to have working call lights in all residents rooms. Call light in R17 room has been repaired. All call lights have been checked to ensure in proper working order. Call light policy will reviewed at the staff inservice on 3/19/19. Work orders will be completed by staff and provided to maintenance for repair. Maintenance will report to NHA/DON at time of issue so that they are aware of repairs needed. Findings will be reviewed at the QAPI meeting.<br><br>Call lights will be audited monthly x 3 months to ensure all are in proper working | 3/19/19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 919 | Continued From page 42<br>admission to the facility with the last fall occurring last weekend which resulted in emergency department visit. R17 indicated they scanned her head and x-rayed her hip and "everything turned out okay."<br><br>During an observation and interview on 2/10/19, at 2:42 p.m., R17's call light did not illuminate outside the room. Nursing assistant (NA)-C answered the call light stating "I know it is R17's call light because hers is the only one not working." R17's call light would beep, but did not illuminate outside the room or on the nurses station call board as confirmed by NA-C. NA-C indicated it quit working before R17 moved into the room. NA-C was unsure if the nonfunctioning call light had been reported to maintenance.<br><br>During interview on 2/10/19, at 3:02 p.m., licensed practice nurse (LPN)-A indicated they were aware the call light was not functioning appropriately and that a part is currently on order for repair.<br><br>During interview on 2/11/19, at 10:30 a.m., R17 indicated she had spoken to the director of nursing (DON) requesting to move to another room.<br><br>During observation on 2/11/19, at 11:15 a.m., R17 moved to another room. Maintenance-A was in the room attempting to repair the call light.<br><br>During observation and interview on 2/13/19, at 8:40 a.m., NA- A indicated the call light was still not working in room 107 and she was unaware if parts were on order. Room 107 was vacant.<br><br>During observation and interview on 2/14/19, at | F 919 | order and no repairs are needed. Findings will be reviewed at QAPI | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245464 | A. BUILDING _____ B. WING _____ | C 02/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OSTRANDER CARE AND REHAB** | **305 MINNESOTA STREET OSTRANDER, MN 55961** |

| (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 919 | Continued From page 43 | F 919 | | |

8:32 a.m., NA-H indicated a resident was admitted into room 107 yesterday. NA-H turned on call light, and confirmed no light illuminated outside the room or at the nurses station. NA-H indicated she thought it was fixed but "I guess not."

During interview on 2/14/19, at 8:41 a.m., maintenance-A indicated he replaced out the underhalf and the bulbs, which did not repair the call light illumination. Maintenance-A then tested the wires inside and stated he needs to pull new wires to fix the problem. Maintenance-A further indicated he has not had a chance to let anyone know of required repairs at this time.

During interview 2/14/19, at 9:10 a.m., the administrator indicated she and the DON were not aware the call light was not working in room 107 and they did admit a resident into that room yesterday. The administrator further indicated upon notification this morning regarding the call light not illuminating, the resident was given a loud bell to ring until they can move the resident to another room.

A Call Light Policy was requested but not supplied.