Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 24, 2025

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

RE: CCN: 245464
Cycle Start Date: January 29, 2025

Dear Administrator:

On March 19, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

This inlcudes corrections for survey's exiting on 2/20/25 and 1/29/25.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 28, 2025

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

RE: CCN: 245464
Cycle Start Date: January 29, 2025

Dear Administrator:

On February 13, 2025, we informed you that we may impose enforcement remedies.

On February 20, 2025, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 29, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 29, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 29, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 29, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Ostrander Care And Rehab will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 29, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 29, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information

Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 02/20/2025

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 On 2/18/25 - 2/20/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/18/25 - 2/20/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54647802C(MN00105729). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 880	Infection Prevention & Control	F 880		3/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880 SS=D	Continued From page 1 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 2 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper personal protective equipment (PPE) was used during transfers and catheter care for 1 of 1 resident (R7) reviewed for enhanced barrier precautions (EBP). Findings include: R7's quarterly Minimum Data Set (MDS) dated	F 880	It is the policy of Ostrander Care and Rehab to ensure that proper personal equipment (PPE) is used at the appropriate time during personal cares. R7 remains with a catheter. Staff were education on the use of PPE when caring for the resident during high-contact cares two of which are transfers and catheter care. Residents who are known to be colonized	

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F 880	Continued From page 3 12/29/24 indicated R7 was cognitively intact and had an indwelling catheter. R7's provider orders included urinary catheter 18 french with/30 cc (cubic centimeter) balloon (size of catheter) related to open wounds and decreased mobility. May irrigated with 20-60 ml (milliliters) of NS (normal saline) prn (as needed) if sluggish or suspected blockage. R7's careplan indicated R7 had an indwelling catheter due to pressure ulcer and "please follow EBP when emptying catheter." During an observation and interview on 2/18/25 at 3:34 p.m., an orange sign was noted on R7's door titled EBP indicated staff must wear gown and gloves for "high contact" resident cares including but not limited to transfers and catheter care. During the interview, R7 confirmed they had a catheter. A catheter bag was observed hanging on the side of R7's bed inside a dignity bag. During observation and interview on 02/19/25 at 10:46 a.m., licensed practical nurse (LPN)-A and nursing assistant (NA)-A entered R7's room to perform a dressing change. LPN-A and NA-A put on gloves and disposable yellow gown. After finishing the dressing change, LPN-A removed PPE, washed hands, and left the room. NA-A removed gown and gloves, washed hands, and applied new gloves. NA-B entered R7's room with mechanical lift. NA-B put on gloves. Without a gown, NA-A and NA-B rolled R7 from side to side to place lift sling under R7. NA-A raised R7 in the air with mechanical lift. NA-B held on to sling while R7 was moved to the broda chair (specialized wheelchair). R7 was lowered	F 880	or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) have the potential to be affected. These residents have been reviewed, appropriate signage at room entry and review of care plan has been completed. Staff have been provided education on Enhanced Barrier precautions. Competency will be determined through a post test. Policy and Procedure titled “Enhanced Barrier Precautions” was reviewed and revised as warranted. Staff members (NA)-A and (NA)-B and (LPN)-A were provided education related to enhanced barrier precautions and what and when to wear appropriate PPE. Random audits will be performed twice a shift (2 total per day) to ensure that all staff are following Enhanced Barrier Precaution policy and procedure x2 weeks. Random audits will be performed once a shift (2 total per day) to ensure that all staff are following Enhanced Barrier Precautions policy and procedure x 2 weeks. Random audits will be performed to spot check staff’s following of Enhanced Barrier Precautions. Results of audits will be presented at quarterly QA/QAPI meeting to discuss findings and determine further auditing and frequency of audits. DON and/or designee is responsible for compliance.	

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	245464	A. BUILDING _____ B. WING _____	C 02/20/2025

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OSTRANDER CARE AND REHAB	305 MINNESOTA STREET OSTRANDER, MN 55961

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F 880	Continued From page 4 into the chair. NA-A and NA-B adjusted lift sling to make R7 more comfortable. NA-A removed gloves, washed hands, and returned with a paper towel and urinal to empty R7's catheter bag. Without a gown, NA-A placed the urinal on the paper towel on the floor. NA-A wiped the catheter bag valve with an alcohol wipe before and after emptying the bag into the urinal. NA-A then emptied the urinal in the toilet, rinsed it with water, and again emptied it in the toilet. NA-A removed gloves and washed hands. When interviewed, NA-A stated gowns are worn when assisting nurses with dressing changes only. NA-B stated hands are washed when entering a resident's room. Gowns and gloves are worn when assisting the nurse with dressing changes and when emptying Foley catheters and ostomy bags (a bag used to collect stool from an opening in the abdomen). During an interview on 2/20/25 at 10:50 a.m., the director of nursing/infection preventionist (DON/IP) stated proper PPE of gown and gloves is expected during peri care, dressing changes, bathing, activities of daily living, transferring, and emptying catheter bags. DON/IP confirmed staff should have worn a gown and gloves when R7 was transferred to their broda chair and when the catheter bag was emptied. A policy titled "Enhanced Barrier Precautions (EBP)" dated 5/1/24 indicated EBP is implemented for the prevention of transmission of multidrug-resistant organisms. EBP will be implemented for residents with chronic wounds such as pressure ulcers and/or indwelling medical devices including urinary catheters. PPE is necessary when performing high-contact care activities. High-contact resident care activities	F 880	Date of compliance:03/14/2025	

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F 880	Continued From page 5 include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, devices care or use including urinary catheters, and wound care requiring a dressing.	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 **01 - MAIN BUILDING 01** B. WING _____	**02/20/2025**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/20/2025. At the time of this survey, OSTRANDER CARE AND REHAB 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2025

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** B. WING _____	**02/20/2025**

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

OSTRANDER CARE AND REHAB is a 1 story building with Penthouse and partial basement.

OSTRANDER CARE AND REHAB was constructed in 1968 and was determined to be of Type II (222) construction.

The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm

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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2025**

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 000	Continued From page 2 system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 25 beds and had a census of 18 at the time of the survey. There is a 2-hour fire-rated separation between the nursing home and assisted living facility. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 19.2.10, 7.10, 7.10.1.8. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 02/20/2025 between 10:15 AM and 12:45 PM, it was revealed by observation that the exit sign located in Penthouse area was not illuminated.	K 293	K293-Exit Signs It is the policy of Ostrander Care & Rehab to ensure that all illuminated exit signs are properly lighted. The dim light in Penthouse area was replaced by the electrician on 3/6/2025. All other lights were evaluated for brightness. The maintenance director will check the brightness of the emergency lighting monthly and to schedule replacement on an as needed basis.	3/10/25

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K 293	Continued From page 3 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 293	Results of audits will be presented at quarterly QA/QAPI meeting to discuss findings and determine further auditing and frequency of audits. The maintenance director and/or designee is responsible for compliance. Date of compliance: 3/6/2025	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of documentation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of	K 353	K353-Sprinkler System It is the policy of Ostrander Care & Rehab to ensure that the sprinkler system is maintained per the NFPA 101 Life Safety Code standards. The cable in the Basement Maintenance Shop Area was removed and rehung so	3/10/25

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K 353	Continued From page 4 Water-Based Fire Protection Systems, section(s), 5.2.2, 5.2.2.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/20/2025 between 10:15 AM and 12:45 PM, it was revealed by observation in the Basement Maintenance Shop Area that cable(s) were found zip-tied to the Sprinkler System piping. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	the cable was no longer zip-tied to the Sprinkler System piping by the Maintenance Supervisor. The maintenance supervisor completed a walk through to audit the sprinkler system to ensure there were no other cables zip-tied to the sprinkler system piping. Results of audits will be presented at quarterly QA/QAPI meeting to discuss findings and determine further auditing and frequency of audits. The maintenance director and/or designee is responsible for compliance. Date of compliance: 3/10/2025	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		3/10/25

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K 923	Continued From page 5 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5, 11.3.2.1. This deficient finding could have a widespread impact on the residents within the facility., Findings include: On 02/20/2025 between 10:15 AM and 12:45 PM, it was revealed by observation that a Med Gas (O2) Storage Room was found unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	K923-Gas Equipment Storage It is the policy of Ostrander Care & Rehab to ensure that all med gas canisters (empty & full) are stored in a secured location. The maintenance supervisor rearranged the locked Oxygen room to include full and empty canisters in the same location and ensured the area is clearly labeled to delineate between full and empty cannisters. All staff were educated on the change and reviewed the signage and location of the full and empty cannisters and that they are secured. The maintenance supervisor will complete weekly audits to ensure that cannisters are being stored properly and are secured. Results of audits will be presented at quarterly QA/QAPI meeting to discuss findings and determine further auditing	

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K 923	Continued From page 6	K 923	and frequency of audits. The maintenance director and/or designee is responsible for compliance. Date of compliance: 2/25/2025	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed to provide documentation of education and staff training per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.5.2.1, 11.5.2.1.1, 11.5.2.1.2, 11.5.2.1.3 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/20/2025 between 10:15 AM and 12:45 PM, it was revealed by a review of available documentation that documentation presented for review was generic in content and did not provide confirmation that staff are receiving initial and continuing education on risks associated with the handling of Med Gas (O2) and cylinders.	K 926	K926 Gas Equipment-Qualifications and Training It is the policy of Ostrander Care & Rehab to ensure that staff are educated upon hire and annually on Medical Gas safety guidelines and usage requirements and documentation of all staff education is kept with the training information. The training information was reviewed and updated to be more in depth and staff have completed training and a post test to verify understanding of safety guidelines and usage requirements on medical gas. The Director of Nursing and/or designee will review training upon hire and annually and audit compliance. Results of audits will be presented at quarterly QA/QAPI meeting to discuss findings and determine further auditing	3/12/25

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K 926	Continued From page 7 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 926	and frequency of audits. The Director of Nursing and/or designee is responsible for compliance. Date of compliance: 3/12/2025	