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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8L7Q

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 **11/16/2014** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

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 :
Gary Nederhoff, Unit Supervisor 11/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/17/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
11/12/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245464

November 17, 2014

Ms. Marian Rauk, Administrator
Ostrander Care And Rehab
305 Minnesota Street
Ostrander, Minnesota 55961

Dear Ms. Rauk:

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 October 24, 2014 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 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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 17, 2014

Ms. Marian Rauk, Administrator
Ostrander Care And Rehab
305 Minnesota Street
Ostrander, Minnesota 55961

RE: Project Number S5464026

Dear Ms. Rauk:

On October 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 2, 2014. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On November 16, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 30, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 24, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 2, 2014, effective October 24, 2014 and therefore remedies outlined in our letter to you dated October 14, 2014, will not 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245464	A. Building B. Wing	11/16/2014

Name of Facility	Street Address, City, State, Zip Code
OSTRANDER CARE AND REHAB	305 MINNESOTA STREET OSTRANDER, MN 55961

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **10/24/2014**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **10/24/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/24/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **10/24/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/KFD	11/17/2014	10160	11/16/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/2/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245464	A. Building B. Wing 01 - MAIN BUILDING 01	10/30/2014

Name of Facility	Street Address, City, State, Zip Code
OSTRANDER CARE AND REHAB	305 MINNESOTA STREET OSTRANDER, MN 55961

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 10/20/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/KFD	**Date:** 11/17/2014	**Signature of Surveyor:** 25822	**Date:** 10/30/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/29/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8L7Q

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 **10/02/2014** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 10/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/10/2014 (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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3055 3135

October 14, 2014

Ms. Marian Rauk, Administrator
Ostrander Care And Rehab
305 Minnesota Street
Ostrander, Minnesota 55961

RE: Project Number S5464026

Dear Ms. Rauk:

On October 2, 2014, 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 11, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 11, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 January 2, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

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 April 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245464	A. BUILDING _____ B. WING _____	10/02/2014

OCT 27 2014
MN Dept of Health
Rochester

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	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156 10-27-14 GPN	F156 The Director of Nursing will provide the notice of Medicare non coverage 48hours prior to the non coverage date. In addition, the Director of Nursing will provide the SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to residents who intend to remain in the facility and receive services after the date of Medicare non coverage. The business office will audit and ensure that all appropriate forms are being completed and remain on file.	10/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marian Rauk — TITLE: Administrator — (X6) DATE: 10/24/14

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 _____ B. WING _____	10/02/2014

MN Dept of Health Rochester

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OSTRANDER CARE AND REHAB	305 MINNESOTA STREET OSTRANDER, MN 55961

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OCT 27 2014
MN Dept of Health
Rochester

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of all Medicare Part A skilled services for 1 of 3 residents (R25) reviewed for liability notice and beneficiary appeal rights. Findings include: R25 had been discharged from Medicare Part A on 6/20/14, and remained in the facility until they discharged from the facility on 6/25/14. The facility had not provide R25 an SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform of potential liability for non-covered services and of right to appeal the denial to Medicare. During an interview on 10/1/14, at 8:55 a.m.,	F 156		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID 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 _____ OCT 27 2014 MN Dept of Health Rochester	10/02/2014

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F 156	Continued From page 3 business office manager (BOM)-B had stated R25 had stayed in the facility as private pay after R25 had been discharged from Medicare Part A on 6/20/14. During interview on 10/1/14, at 9:12 a.m., director of nursing verified he had not provided R25 the SNFABN. The facility policy/procedures related to SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 had been requested but not provided.	F 156		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess oral status for 1 of 3 residents (R21) reviewed for dental needs.	F 274		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID 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 _____	10/02/2014

OCT 27 2014
MN Dept of Health
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F 274	Continued From page 4 Findings include: R21 had been admitted on 8/22/12 found on the face sheet. R21's physician progress note dated 9/24/14, identified diagnoses of but not limited to congestive heart failure and diabetes mellitus. Observation on 9/30/14, at 10:50 a.m., revealed R21 had a broken tooth on upper left side of gum line. During observation on 10/1/14, at 1:32 p.m., registered nurse (RN)-A verified R21 had a broken tooth on upper left side of gum line. Review of R21's significant change minimum data set (MDS) dated 9/2/14, had not identified broken natural teeth. Further review of R21's records identified the last Brief Oral Health Status Examination (BOHSE) completed for R21 had been dated 3/12/14. During interview on 10/1/14, at 1:25 p.m., RN-A verified an oral assessment had not been completed for R21's significant change MDS dated 9/2/14, and broken tooth had not been identified and the last oral assessment completed for R21 had been on 3/12/14. During interview on 10/2/14, at 9:03 a.m., director of nursing had stated expectation would be an oral assessment be completed with significant change MDS and a full comprehensive assessment be done. Document review of the facility Oral Assessment Policy undated, read, "Policy: Oral assessments will be performed upon admission. In addition,	F 274	F 274 The MDS coordinator has completed an audit of the current assessments and an oral assessment has been performed for residents with a significant change. The MDS coordinator will be responsible for completing these assessments with any significant change and with quarterly reviews. The Director of Nursing will audit these assessments with submissions of the MDS to ensure that all appropriate assessments are being performed and that the findings are care planned if necessary.	10/24/14

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F 274	Continued From page 5 Oral assessments will be completed quarterly and with any significant changes."	F 274		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility had not identified resident specific indications for use for psychotropic medications, nor monitored for effectiveness of the psychoactive medication, nor attempted to use	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OCT 27 2014
MN Dept of Health Rochester

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F 329	Continued From page 6 non-pharmacological interventions before using psychoactive medications for 2 of 5 residents (R21, R22) also no clinical symptoms were identified to justify the increase in an antidepressant medication for 1 of 5 residents (R5) who had been reviewed for unnecessary medications. Findings include: Lack of clear indication of use of psychoactive medication. Lack of non-pharmacological interventions attempted before use of psychoactive medication, lack of effectiveness of psychoactive as needed (PRN) use: R21 had been admitted on 8/22/12 according to the face sheet. R21's physician progress note dated 9/24/14, identified diagnoses of but not limited to congestive heart failure and diabetes mellitus. Review of R21's significant change minimum data set (MDS) dated 9/2/14, identified Brief Interview for Mental Status (BIMS) score of six, severe cognitive impairment. Review of R21's physician orders identified order for Ativan (an anti-anxiety medication) 0.5 mg (milligrams) by mouth TID (three times daily) PRN (as needed) dated 8/16/14. Review of R21's nurse's notes dated 8/16/14, revealed resident very anxious and restless with difficulty breathing, new order for Ativan 0.5 mg TID PRN for anxiety, further review of R21's progress notes dated 8/15/14 through 10/1/14 identified no specific symptoms for use of Ativan or non-pharmacological interventions tried before obtaining order for Ativan had been documented. Review of R21's physician progress notes dated 8/17/14 through 9/30/14, had no documentation	F 329	F 329 The DON has addressed the current lack of documentation regarding target behaviors by reviewing the current psychotropic medications and including those in the MAR. The nursing staff will receive education as to the use of non-pharmacological interventions and the need to document these as well as documenting behaviors appropriately. This education is ongoing and will be discussed with the nursing staff individually by the DON. In addition, the DON will discuss the use of psychoactive medications for R22 and R5 with the medical director and determine if a gradual dose reduction is appropriate and document as to whether this is attempted, successful or unsuccessful and the behaviors noted. Continued →	10/24/14

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

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MN Dept of Health
Rochester

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F 329	Continued From page 7 of Ativan or physician justification for use of Ativan. Document review of R21's care plan dated 9/26/14, identified problem of but not limited to fluid volume excess related to congestive heart failure and approaches of but not limited to report anxiety/restlessness. R21's care plan had no documentation of specific symptoms related to Ativan use. Document review of R21 medication/treatment summary report and recent PRN med use sheets for month of 9/14, revealed anti-anxiety monitor for behavior symptoms rejects care, Ativan 0.5 mg three times a day as needed for anxiety and Ativan 0.5 mg had been administered on 9/20/14 given for anxiety, breathing heavy, cannot sit still and on 9/25/14 for anxiety problems breathing. No specific symptoms had been identified for use of Ativan, effectiveness of medication after administration on 9/20/14 had not been documented and no documentation of Non-pharmacological interventions tried before administration of Ativan on 9/20/14 and 9/25/14 had been documented. Review of R21's psychoactive medication quarterly evaluation dated 9/2/14 identified drug: Ativan, dosage: 0.5 mg, frequency: TID PRN, diagnosis: anxiety, adverse reactions: none apparent, evaluation: appears controlled, behavior warranting use of medication: had no documentation and ineffective interventions: had no documentation. During interview on 10/2/14, at 9:13 a.m., director of nursing had stated would expect physician to address Ativan on rounds, especially since it was	F 329	The MDS coordinator will be responsible for auditing this system and making sure that the appropriate target behaviors are listed on the MAR with regards to psychoactive medication use. The MDS coordinator and DON will together ensure that appropriate guidelines are met and documented.	

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	245464	A. BUILDING _____ B. WING _____ OCT 27 2014 MN Dept of Health	10/02/2014

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F 329	Continued From page 8 a change. Director of nursing had stated would expect effectiveness of Ativan to be documented and non-pharmacological intervention tried before giving the Ativan. Policy for PRN psychotropic medications had been requested but not provided. R22 was admitted on 8/26/13 according to the face sheet. The physician's progress notes dated 9/17/14 identified R22's diagnoses of but not limited to history of transient ischemic attack (TIA), hypertension, and history of generalized anxiety/depression. Review of R22's significant change minimum data set (MDS) dated 8/12/14, identified Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. R22 scored 0 on the Patient Health Questionnaire (PHQ-9) indicating no signs or symptoms of depression. Review of R22's physician ' s order dated 9/17/14 included Ativan (an anti-anxiety medication) 0.5 mg (milligrams) by mouth twice a day as needed for anxiety. Instructions: Don't administer if over sedated, confused, dizzy, etc. Monitor every 3 months. Please try non-medication therapies before giving the Ativan-document the therapies and the outcome. Also, the orders included Effexor Extended Release (an antidepressant) 37.5 mg capsule by mouth daily for major depressive disorder. The psychoactive medication quarterly evaluation for the use of Effexor dated 5/9/14 indicated that no behaviors noted at this time. History of refusing cares, but none in last week. MD can review on rounds if change is needed. The psychoactive quarterly evaluation dated 8/11/14 for the use of Effexor indicated that behavior warranting use of medication was refusal of cares.	F 329		

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F 329	Continued From page 9 The monthly behavior monitoring flow sheets for the months dated December, 2013 through August 2014 was reviewed for the use of Effexor and Ativan. The flow sheets indicated the behavior for Ativan being monitored was anxiety, about not being able to return home. The behavior for Effexor being monitored was refusal of cares. Documentation indicated that no behaviors were noted. The MDS dated 9/15/14 indicated no rejection of cares. Review of the PRN (as needed) medication record for the month of September, 2014 indicated that R22 received Ativan 7 times for anxiety, restless, anxiety for going to the dentist, agitation, on call light not sure of need, difficulty transferring, legs are crawling and cannot settle down for bed. In August 2014 R22 received Ativan 3 times for anxiety, and for July 2014, R22 received Ativan 8 times for anxiety, too anxious to sleep, "I've worked myself into a tizzy and I don't know why, unable to sleep." R22's care plan dated 2/18/14 had a problem titled psychosocial well- being related to depression/situational anxiety. The interventions included to provide protection to resident and assure resident of personal concerns and her welfare, give medications prescribed by physician to treat depression and for situational anxiety, follow resident ' s activities to see what causes situations anxiety to defuse those situations, reapproached 10-15 minutes later, try different staff member. Targeted behaviors were refusal of cares, anxious of not being able to return home. A review of the nurse's notes from June 2014 through September 30, 2014 showed no documentation of non-pharmacological interventions prior to giving the Ativan. A review of the monthly pharmacy review dated	F 329		

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 _____	10/02/2014

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F 329	Continued From page 10 6/16/14 indicated that the pharmacist would address with the director of nursing (DON) again regarding no non-pharmacological documentation prior to administration of the as needed psych needs. During an interview with the nursing assistant (NA)-B on 10/1/14 at 9:30 a.m., NA-B indicated that she wasn't aware of or had seen any behaviors with R22. During an interview with NA -A on 10/1/14 at 9:30 a.m., NA -A stated R22 had no behaviors, but that she didn't like her bath. R22 didn't refuse her bath though. During an interview with the licensed practical nurse (LPN)-A on 10/2/14 at 9:30 a.m., LPN-A indicated that R22 a few times "here and there" shows signs of depression, mostly to do with her family. Normally one on ones worked for R22. If R22 would get overly anxious, then they give her a prn (as needed) Ativan. LPN-A stated she thought R22's issues had more to do in the transition period of when she first came to the nursing home (admission was August 2013.) During an interview with R22 on 10/2/14 at 9:35 a.m., R22 indicated that after she's been in bed awhile she gets anxious. R22 stated she worried about her kids. R22 indicated that she puts pillows under her legs for restless legs. R22 stated that she had a dentist appointment today to get a filling and that she didn't like the dentist and sometimes she needs an Ativan. She tells the staff when she needs an Ativan. R22 indicated that she had no sadness and stated she liked it here. When asked about taking a bath, R22 indicated that she used to only get one bath a week when she first got here and that wasn't enough so she asked for two a week. During interview with the director of nursing	F 329		

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F 329	Continued From page 11 (DON) on 10/2/14, the DON stated that he feels R22 does make request and needs the Ativan from time to time. DON indicated he knows he needs to"flush out" more on what the staff is giving the Ativan for and what behaviors. DON stated the behaviors needed to be more specific on when R22 needed the Ativan. DON stated that the staff does provide non-pharmacological interventions but they weren't good at documenting them. Lack of clinical symptoms to justify the increase of an antidepressant medication: R5's provider orders signed 9/3/14 identified R5 had diagnoses of depression, chronic pain, and osteoporosis. R5's annual Minimum Data Set (MDS) dated 5-27-14 14 indicated R5 had a brief interview for mental status (BIMS) score of 11 indicating moderate cognitive impairment and R5 scored 0 on the PHQ-9 (Patient Health Questionnaire) indicating no signs or symptoms of depression. R5's provider orders dated 9/3/14 included citalopram (Celexa an antidepressant) 40 milligrams (mg) daily. On 7/7/14, the Celexa was increased to 40 mg daily from 20 mg daily. The physician's nursing home visit note, dated 7/8/14 read, "History of major depression and anxiety. Is in remission. We did back down on her Celexa from 40 mg to 20 mg; however, note that her anxiety and some of the other symptoms she is having seems to be increasing, so we will increase her Celexa back from 20 mg to 40 mg a day and will see if these symptoms resolve." However, there was no information provided when requested by the facility in regards to R5 having "anxiety and some of the other symptoms she is having seems to be increasing" as the	F 329		

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F 329	Continued From page 12 physician wrote in his progress note dated 9/3/14 to support the decision to increase the Celexa dose. R5's monthly behavior monitoring flow sheet dated July 2014 revealed R5 received Celexa for a diagnosis of major depression. The targeted behaviors were identified on the flow sheet as manipulative behavior, striking out and name calling and revealed no concerns for the month of July 2014. The progress notes provided from the facility from 12-5-13 to 9-11-14 revealed only one entry had been made regarding mood concerns for R5. The progress note dated 6/22/14 indicated the resident had requested "something" for her nerves and the physician was contacted and the facility received an order for Lorazepam 0.5 mg as needed. No additional documentation was provided to support the increase in the Celexa, when requested. On 10/2/14 at 9:36 a.m. the director of nursing (DON) stated the progress note dated 6/22/14 justified the need for the increase in Celexa as R5 had requested something for her nerves. The DON verified this was the only documentation the facility had to support the gradual dose reduction failure for Celexa and the need to increase the Celexa back to the original dose of 40 mg a day.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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	245464	A. BUILDING _____ B. WING _____	10/02/2014

OCT 27 2014
MN Dept of Health
Rochester

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OSTRANDER CARE AND REHAB	305 MINNESOTA STREET OSTRANDER, MN 55961

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F 428	Continued From page 13 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the pharmacist had not identified on monthly medication assessments the lack of resident specific indications for use for psychotropic medications, nor monitored for effectiveness of the psychoactive medication, nor attempted to use non-pharmacological interventions before using psychoactive medications for 2 of 5 residents (R21, R22) also no clinical symptoms were identified to justify the increase in an antidepressant medication for 1 of 5 residents (R5) who had been reviewed for unnecessary medications. Findings include: Lack of clear indication of use of psychoactive medication. Lack of non-pharmacological interventions attempted before use of psychoactive medication, lack of effectiveness of psychoactive as needed (PRN) use: R21 had been admitted on 8/22/12 according to the face sheet. R21's physician progress note dated 9/24/14, identified diagnoses of but not limited to congestive heart failure and diabetes mellitus. Review of R21's significant change minimum data set (MDS) dated 9/2/14, identified Brief Interview for Mental Status (BIMS) score of	F 428	F 428 The consultant pharmacist and DON have collaborated and corrected the identified issues as of 10/22/14. The DON and consultant pharmacist will work in tandem to ensure that issues are identified and that appropriate indications are in place for the use of psychoactive medications for current residents. The DON will keep a list of new psychoactive medication orders to provide to the pharmacist at each monthly visit to ensure that new medications are being addressed in full. The pharmacist will then determine if appropriate indications for psychotropic medications, monitoring of effectiveness of these medications and non-pharmacological interventions are in place.	10/24/14

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F 428	Continued From page 14 six, severe cognitive impairment. Review of R21's physician orders identified order for Ativan (an anti-anxiety medication) 0.5 mg (milligrams) by mouth TID (three times daily) PRN (as needed) dated 8/16/14. Review of R21's nurse's notes dated 8/16/14, revealed resident very anxious and restless with difficulty breathing, new order for Ativan 0.5 mg TID PRN for anxiety, further review of R21's progress notes dated 8/15/14 through 10/1/14 identified no specific symptoms for use of Ativan or non-pharmacological interventions tried before obtaining order for Ativan had been documented. Review of R21's physician progress notes dated 8/17/14 through 9/30/14, had no documentation of Ativan or physician justification for use of Ativan. Document review of R21's care plan dated 9/26/14, identified problem of but not limited to fluid volume excess related to congestive heart failure and approaches of but not limited to report anxiety/restlessness. R21's care plan had no documentation of specific symptoms related to Ativan use. Document review of R21 medication/treatment summary report and recent PRN med use sheets for month of 9/14, revealed anti-anxiety monitor for behavior symptoms rejects care, Ativan 0.5 mg three times a day as needed for anxiety and Ativan 0.5 mg had been administered on 9/20/14 given for anxiety, breathing heavy, cannot sit still and on 9/25/14 for anxiety problems breathing. No specific symptoms had been identified for use of Ativan, effectiveness of medication after administration on 9/20/14 had not been documented and no documentation of	F 428		

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

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F 428	Continued From page 15 Non-pharmacological interventions tried before administration of Ativan on 9/20/14 and 9/25/14 had been documented. Review of R21's psychoactive medication quarterly evaluation dated 9/2/14 identified drug: Ativan, dosage: 0.5 mg, frequency: TID PRN, diagnosis: anxiety, adverse reactions: none apparent, evaluation: appears controlled, behavior warranting use of medication: had no documentation and ineffective interventions: had no documentation. During interview on 10/2/14, at 9:13 a.m., director of nursing had stated would expect physician to address Ativan on rounds, especially since it was a change. Director of nursing had stated would expect effectiveness of Ativan to be documented and non-pharmacological intervention tried before giving the Ativan. Policy for PRN psychotropic medications had been requested but not provided. R22 was admitted on 8/26/13 according to the face sheet. The physician's progress notes dated 9/17/14 identified R22's diagnoses of but not limited to history of transient ischemic attack (TIA), hypertension, and history of generalized anxiety/depression. Review of R22's significant change minimum data set (MDS) dated 8/12/14, identified Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. R22 scored 0 on the Patient Health Questionnaire (PHQ-9) indicating no signs or symptoms of depression. Review of R22's physician ' s order dated 9/17/14 included Ativan (an anti-anxiety medication) 0.5 mg (milligrams) by mouth twice a day as needed for anxiety. Instructions: Don't administer if over	F 428		

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F 428	Continued From page 16 sedated, confused, dizzy, etc. Monitor every 3 months. Please try non-medication therapies before giving the Ativan-document the therapies and the outcome. Also, the orders included Effexor Extended Release (an antidepressant) 37.5 mg capsule by mouth daily for major depressive disorder. The psychoactive medication quarterly evaluation for the use of Effexor dated 5/9/14 indicated that no behaviors noted at this time. History of refusing cares, but none in last week. MD can review on rounds if change is needed. The psychoactive quarterly evaluation dated 8/11/14 for the use of Effexor indicated that behavior warranting use of medication was refusal of cares. The monthly behavior monitoring flow sheets for the months dated December, 2013 through August 2014 was reviewed for the use of Effexor and Ativan. The flow sheets indicated the behavior for Ativan being monitored was anxiety, about not being able to return home. The behavior for Effexor being monitored was refusal of cares. Documentation indicated that no behaviors were noted. The MDS dated 9/15/14 indicated no rejection of cares. Review of the PRN (as needed) medication record for the month of September, 2014 indicated that R22 received Ativan 7 times for anxiety, restless, anxiety for going to the dentist, agitation, on call light not sure of need, difficulty transferring, legs are crawling and cannot settle down for bed. In August 2014 R22 received Ativan 3 times for anxiety, and for July 2014, R22 received Ativan 8 times for anxiety, too anxious to sleep, "I've worked myself into a tizzy and I don't know why, unable to sleep." R22's care plan dated 2/18/14 had a problem titled psychosocial well- being related to	F 428		

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F 428	Continued From page 17	F 428		

depression/situational anxiety. The interventions included to provide protection to resident and assure resident of personal concerns and her welfare, give medications prescribed by physician to treat depression and for situational anxiety, follow resident ' s activities to see what causes situations anxiety to defuse those situations, reapproached 10-15 minutes later, try different staff member. Targeted behaviors were refusal of cares, anxious of not being able to return home.

A review of the nurse's notes from June 2014 through September 30, 2014 showed no documentation of non-pharmacological interventions prior to giving the Ativan.

A review of the monthly pharmacy review dated 6/16/14 indicated that the pharmacist would address with the director of nursing (DON) again regarding no non-pharmacological documentation prior to administration of the as needed psych needs.

During an interview with the nursing assistant (NA)-B on 10/1/14 at 9:30 a.m., NA-B indicated that she wasn't aware of or had seen any behaviors with R22.

During an interview with NA -A on 10/1/14 at 9:30 a.m., NA -A stated R22 had no behaviors, but that she didn't like her bath. R22 didn't refuse her bath though.

During an interview with the licensed practical nurse (LPN)-A on 10/2/14 at 9:30 a.m., LPN-A indicated that R22 a few times "here and there" shows signs of depression, mostly to do with her family. Normally one on ones worked for R22. If R22 would get overly anxious, then they give her a prn (as needed) Ativan. LPN-A stated she thought R22's issues had more to do in the transition period of when she first came to the nursing home (admission was August 2013.)

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F 428	Continued From page 18 During an interview with R22 on 10/2/14 at 9:35 a.m., R22 indicated that after she's been in bed awhile she gets anxious. R22 stated she worried about her kids. R22 indicated that she puts pillows under her legs for restless legs. R22 stated that she had a dentist appointment today to get a filling and that she didn't like the dentist and sometimes she needs an Ativan. She tells the staff when she needs an Ativan. R22 indicated that she had no sadness and stated she liked it here. When asked about taking a bath, R22 indicated that she used to only get one bath a week when she first got here and that wasn't enough so she asked for two a week. During interview with the director of nursing (DON) on 10/2/14, the DON stated that he feels R22 does make request and needs the Ativan from time to time. DON indicated he knows he needs to"flush out" more on what the staff is giving the Ativan for and what behaviors. DON stated the behaviors needed to be more specific on when R22 needed the Ativan. DON stated that the staff does provide non-pharmacological interventions but they weren't good at documenting them. Lack of clinical symptoms to justify the increase of an antidepressant medication: R5's provider orders signed 9/3/14 identified R5 had diagnoses of depression, chronic pain, and osteoporosis. R5's annual Minimum Data Set (MDS) dated 5-27-14 14 indicated R5 had a brief interview for mental status (BIMS) score of 11 indicating moderate cognitive impairment and R5 scored 0 on the PHQ-9 (Patient Health Questionnaire) indicating no signs or symptoms of depression.	F 428		

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F 428	Continued From page 19 R5's provider orders dated 9/3/14 included citalopram (Celexa an antidepressant) 40 milligrams (mg) daily. On 7/7/14, the Celexa was increased to 40 mg daily from 20 mg daily. The physician's nursing home visit note, dated 7/8/14 read, "History of major depression and anxiety. Is in remission. We did back down on her Celexa from 40 mg to 20 mg; however, note that her anxiety and some of the other symptoms she is having seems to be increasing, so we will increase her Celexa back from 20 mg to 40 mg a day and will see if these symptoms resolve." However, there was no information provided when requested by the facility in regards to R5 having "anxiety and some of the other symptoms she is having seems to be increasing" as the physician wrote in his progress note dated 9/3/14 to support the decision to increase the Celexa dose. R5's monthly behavior monitoring flow sheet dated July 2014 revealed R5 received Celexa for a diagnosis of major depression. The targeted behaviors were identified on the flow sheet as manipulative behavior, striking out and name calling and revealed no concerns for the month of July 2014. The progress notes provided from the facility from 12-5-13 to 9-11-14 revealed only one entry had been made regarding mood concerns for R5. The progress note dated 6/22/14 indicated the resident had requested "something" for her nerves and the physician was contacted and the facility received an order for Lorazepam 0.5 mg as needed. No additional documentation was provided to support the increase in the Celexa, when requested.	F 428		

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F 428	Continued From page 20 On 10/2/14 at 9:36 a.m. the director of nursing (DON) stated the progress note dated 6/22/14 justified the need for the increase in Celexa as R5 had requested something for her nerves. The DON verified this was the only documentation the facility had to support the gradual dose reduction failure for Celexa and the need to increase the Celexa back to the original dose of 40 mg a day.	F 428		

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	245464	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/29/2014

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Ostrander Care and Rehab was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	Pack 10-24-14 RECEIVED OCT 23 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DOC: 11-11-14
EXIT: 12-2-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marian Rauk	Administrator	10/20/14

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ostrander Care and Rehab is a 2-story building, with a partial basement. This facility was constructed in 1968 and was determined to be of Type V(111) construction. The facility is fully sprinklered since 1/4/2013. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 25 beds and had a census of 25 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062 SS=F	Continued From page 2 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 2-1. This deficient practice could affect all 25 residents. Findings include: On facility tour between 2:30 PM and 4:30 PM on 09/29/2014, a review of the annual fire sprinkler inspection records revealed there has been no annual inspection since system was installed on 1/4/2013. This deficient practice was confirmed by the Director of Maintenance (TF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062	1. An annual fire sprinkler inspection was completed on October 6, 2014. 2. Maintenance will set a schedule for this inspection on an annual basis from October 2014 forward. 3. Maintenance and Administration will monitor to assure that this practice is continued so there is an annual inspection yearly. 4. Completion date: 10/20/14.	