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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B3FJ

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 **01/18/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **25** (L18)

13.Total Certified Beds **25** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 01/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/25/2018 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245464
January 24, 2018

Ms. Janice Howe, Administrator
Ostrander Care and Rehabilitation
305 Minnesota Street
Ostrander, MN 55961

Dear Ms. Howe:

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 January 12, 2018 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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 24, 2018

Ms. Janice Howe, Administrator
Ostrander Care and Rehabilitation
305 Minnesota Street
Ostrander, MN 55961

RE: Project Number S5464029

Dear Ms. Howe:

On December 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 18, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 16, 2018 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 December 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 12, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2017, effective January 12, 2018 and therefore remedies outlined in our letter to you dated December 15, 2017, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B3FJ

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(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 **12/04/2017** (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) :

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 12/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/24/2018 (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:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2017

Ms. Janice Howe, Administrator
Ostrander Care and Rehabilitation
305 Minnesota Street
Ostrander, MN 55961

RE: Project Number S5464029

Dear Ms. Howe:

On December 4, 2017, 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 electronically delivered CMS-2567, whereby corrections are required.

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - 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, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (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 January 13, 2018, 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 January 13, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

Failure to submit an acceptable ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 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.

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 March 4, 2018 (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 June 4, 2018 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245464	A. BUILDING _____ B. WING _____	12/04/2017

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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted November 28, 29, 30, December 1 & 4, 2017, during a recertification survey. 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.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following:	E 015		1/12/18

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

Electronically Signed | 12/22/2017

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 _____	12/04/2017

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 015	Continued From page 1 (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure policies and procedures addressed supplies needed for the care of facility residents during a community emergency event. This had the potential to affect all 20 residents currently residing in the facility. Findings include:	E 015	It is the policy of Care and Rehab-Ostrander that in the event of an emergency provisions of sustenance will be supplied for staff and residents. We have developed a policy that outlines how we would supply food, water, medical and pharmaceutical supplies. This policy includes sources of alternate energy to	

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 _____	12/04/2017

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 015	Continued From page 2 The facility Emergency policies and procedures were reviewed with the administrator and the housing manager. During the review it was revealed the facility did not have policies for the following: Emergency plan includes policies and procedures for the provision of subsistence needs including: pharmaceutical supplies for patients and to provide for sewage and waste disposal. On 12/1/17, at 10:49 a.m. both the facility administrator and the housing manager verified the facility did not include policies and procedures for provision of pharmaceutical supplies and sewage and waste disposal.	E 015	maintain temperatures to protect residents, ensure emergency lighting, fire detection, extinguishing, and alarm systems along with sewage and waste disposal.	
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.	E 018		1/12/18

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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 018	Continued From page 3 *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and	E 018		

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E 018	Continued From page 4 procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an Emergency Preparedness Plan (EPP) which identified how residents and staff were to be tracked in the event of an emergency. This had the potential to affect all 20 residents currently residing in the facility, as well as staff and visitors. Findings include: The facility Emergency policies and procedures were reviewed with the administrator and the housing manager. During the review it was revealed the facility did not have policies and procedures for the following: The facility had not developed a system for tracking residents or staff in the event of an emergency. On 12/1/17, at 10:49 a.m. during the emergency preparedness interview both the facility administrator and the housing manager verified the facility did not include policies and procedures for tracking residents or staff in the event of an emergency.	E 018	It is the policy of OCR for a system to track residents and staff in the event of emergency which would require relocation. We have devised a policy and procedure to track residents and staff during relocation-it includes the name and location of the receiving facility or other location.	

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E 026	Continued From page 5	E 026		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop policies and procedures in its emergency plan describing the facility's role in providing care and treatment at alternate care sites under section 1135 act waiver. This had the potential to affect all 20 residents currently residing in the facility as well as visitors and staff. Findings Include:	E 026	It is the policy of OCR to provide care and treatment of residents at alternate care sites in the event of relocation during an emergency. We have developed a policy to include how to provide care and treatment at an alternate care site identified by emergency management officials.	1/12/18

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E 026	Continued From page 6 The facility Emergency policies and procedures were reviewed with the administrator and the housing manager. During the review it was revealed the facility did not have policies for the following: The facility's role in providing care and treatment at alternate care sites under section 1135 act waiver. On 12/1/17 at 10:49 a.m. during the emergency preparedness interview both the facility administrator and the housing manager verified the facility did not include policies and procedures for The facility's role in providing care and treatment at alternate care sites under a 1135 waiver.	E 026		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a communication plan, which included a method for sharing appropriate information from the emergency plan that the facility had determined was appropriate with	E 035	It is the policy of OCR to maintain an emergency preparedness communication plan. A policy was developed for a communication plan to share with our residents and families in the event of an	1/12/18

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E 035	Continued From page 7 residents, families or representatives. This had the potential to affect 20 residents currently residing in the facility, as well as staff and visitors. Findings include: On 12/1/17, at 10:49 a.m. the facility emergency policies and procedures were reviewed with the administrator and the housing manager. During the review it was revealed and verified the facility did not develop a communication plan, which included a method for sharing appropriate information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives. The plan included to share information at resident council meetings, but this had not been done in the past year. However, the plan did not include how the information would be shared with residents that did not attend resident council. The plan included to post appropriate information from the emergency plan on the bulletin board, but did not include how residents or family members would be made aware this information was available for review.	E 035	emergency. A letter was mailed to all residents and representatives to inform them of our emergency plan and its location in the facility for review. This letter is also presented to new admissions upon arrival to the facility.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at	E 037		1/12/18

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E 037	Continued From page 8 least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. This is what's in SOM but is missing here. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training	E 037		

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E 037	Continued From page 9 program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.	E 037		

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E 037	Continued From page 10 (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.	E 037		

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E 037	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide training for new and current staff regarding policy and procedures in the facility's emergency preparedness plan (EPP). This had the potential to affect all 20 residents currently residing in the facility, as well as staff and visitors. Findings include: On 12/1/17, at 10:49 a.m. during the emergency preparedness interview, both the facility administrator and the housing manager stated the facility did not have a process in place for training for new staff upon hire or current staff on an annual basis on the policies and procedures in the EPP.	E 037	It is the policy of OCR to train new and current employees on the Emergency Preparedness Plan in the event of an emergency. The facility has developed a policy to include how new and current employees will be trained on the Emergency Preparedness plan. This information will be updated and reviewed with staff on an annual basis.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual,	E 039		1/12/18

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E 039	Continued From page 12 facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as	E 039		

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E 039	Continued From page 13 needed. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to become involved with any training for emergency preparedness, whether community event or table top exercises. This had the potential to affect all 20 residents currently residing in the facility. Findings included: On 12/1/17, at 10:49 a.m. during the emergency preparedness interview both the facility administrator and the housing manager verified the facility did not participate in a community wide emergency preparedness event in the last year and verified the facility had not preformed any tabletop exercises.	E 039	It is the policy of OCR to conduct exercises to test the emergency plan annually. We have contacted the emergency preparedness program coordinator at the county level to participate in a community based exercise. In the event an exercise is not available the facility will conduct a tabletop exercise and revise the emergency plan as needed.	

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F 000	INITIAL COMMENTS A standard recertification survey was conducted November 28, 29, 30, December 1 & 4, 2017. The facility was found not to be in full compliance. Upon receipt of an acceptable electronic 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. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		1/12/18

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

Electronically Signed | 12/22/2017

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

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview the facility failed to maintain a dignified atmosphere for 2 of 2 residents (R3 & R14)who require assistance with eating was observed in the dining room waiting for meals to be served while others in the dining room were receiving their food. Findings include: R3 admitted 12/14/14, according to face sheet with diagnosis of unspecified dementia without with behavioral disturbance who is dependent on staff to eat. Observed R3 on 11/28/17, at 6:00 p.m. in the	F 550	It is the policy of Care & Rehab Ostrander to ensure all residents have the right to live a dignified existence while preserving self determination and communication at their highest practical level. Resident R3 & R14 had no ill effect from not receiving assistance with their meals. All residents of the facility were assessed to ensure that if they needed assistance with dining that staff provide assistance. A new policy was developed in regards to residents that require assistance with dining. No resident that requires assistance with dining are seated at the table until a staff member is present to	

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F 550	Continued From page 2 dining room served pureed meat, scalloped corn and magic cup (nutritional supplement.) R3 been observed to be seated at the dining room table since 5:00 p.m. Observation on 11/30/17, at 7:14 a.m. R3 sitting at the dining table, clothes protector on, sleeping with head tipped down. Noted no food in front of her, no nursing staff in the dining room. Interviewed dietary aide (DA)-A, how long has R3 been in dining room. DA-A stated about half hour and we cannot put food out because she needed help to eat. At 8:13 a.m. R3 was served food. At 8:30 a.m. No attempts by staff to assist R3 to eat her meal. At 8:38 a.m. Director of Nursing (DON) came in dining room requested a magic cup and started to assist R3 to eat. At 8:40 a.m. DON requested drinks for R3 and assisted her to drink some. At 9:27 a.m. R3 continued to sit at dining room table assisted by staff to continue to eat her meal. R14 admitted 10/1/09, according to face sheet, with type 2 diabetes mellitus without complications requires assistance and cueing from staff to eat. On 11/28/17 at 6:12 p.m. R14 sitting in the dining room at the table and was served pureed meat, scalloped corn and given a magic cup (nutritional supplement). R14 was previously observed to be sitting at the table in the dining room before 5:00 p.m. with no staff present. On 11/30/17 at 7:15 a.m. sitting in the dining room eyes closed, moving around in her chair. At 8:05 a.m. R14 continue to sit in the dining room with no staff interaction or food. At 8:13 a.m. R14 had been served food, staff sitting next to R14	F 550	assist. Nursing staff were educated on the new policy and oversight to ensure compliance will be done by the DON or designee.	

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F 550	Continued From page 3 while R14 holding on to her glass and drinking self. R14 waited from 7:15 a.m. to 8:13 a.m. for food and assistance to eat while others in dining room were served/eating meal. Interview with DON on 12/01/17, at 1:57 p.m. Expectation for dependent residents would be to have staff available when food is ready. DON expectation regarding placing residents at the dining table for an extended time when no food can be served, DON stated that no resident should be placed at the table until food is ready to be served and staff available to assist them eat. On 12/04/17, at 1:10 p.m. surveyor requested information on the dignity and dining observation policies and procedures. DON stated they do not have a policy on dignity or proper dining observation, stated it is a standard of care; no resident should be left in the dining room staring at nothing.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583		1/12/18

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F 583	Continued From page 4 right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain confidentiality for 1 of 1 resident (R15) health status was announced and heard by staff and visitors located in hallway by residents room. Findings include: During an observation on 11/30/17, at 2:20 p.m. Surveyor was sitting at the nurses station when licensed practical nurse (LPN)-B loudly called out to another LPN-A down the hallway while walking by the nurses station. LPN-B was easily heard saying in regards to R15, "Just wanted to let you know [R15] fell about 15 minutes ago, I am taking her to go get vitals and blood sugar." On 11/30/17 at 2:30 p.m. during an interview with	F 583	It is the policy of OCR that all medical information of residents remain confidential in whatever form is available. R15 had no ill effect from LPN talking loudly about a fall that R15 had. All staff were reeducated on HIPPA & confidentiality on 12/20/17. This re-education will occur every 3 months X 1 year then annual or as needed. HIPPA education is completed upon hire. Any agency staff that are contracted by the facility will have the same education on first day of working at OCR. Oversight of the staff education to ensure it is completed will be conducted by the DON or designee by auditing the process, to ensure compliance.	

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F 583	Continued From page 5 R15 concerning her fall, LPN-B was in the areas and said, "I should not have called it out in the halls [regarding her health status]. I made a mistake." Interview on 11/30/17 at 2:47 p.m. with director of nursing (DON) and administrator was asked their expectation about maintaining and environment of confidentiality with resident cares/health status. Both the DON and administrator said this should not have happened. They continued to say that the LPN should have taken the other LPN aside and informed of the fall. The DON handed the confidentially policy and HIPAA information to surveyor and said the information is gone through on hire. The Policy titled, Confidentiality Policy reads: to protect and maintain confidentiality of health care and other private information of the residents. Also an employee handbook was provided and on page 20 it reads: under confidentiality/HIPAA; all employees have a special obligation to maintain the security of information that is entrusted to them.	F 583		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		1/12/18

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F 656	Continued From page 6 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently implement the care plan regarding extensive assist of one with eating for 1 of 1 residents (R12) who had been reviewed for nutritional status.	F 656	It is the policy of OCR that comprehensive care plans are developed and implemented by the facility based on assessment of the care needs of the resident. Based on the information a care plan is developed based on the individual	

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F 656	Continued From page 7 Findings include: R12 was observed on 11/28/17, at 6:17 p.m. R12 had food placed in front of her and was observed to not be eating. Registered nurse (RN)-A was asked the length of time the food had placed in front of R12. RN-A stated about an hour, or maybe 45 minutes. A staff member than sat down to assist R12 to eat. R12 told the staff member her potatoes were cold. R12 was observed during breakfast on 11/30/17, at 7:40 a.m. R12 was served oatmeal, apple juice and milk. At 7:44 a.m. R12 was stirring the oatmeal but not eating. At 7:48 a.m. R12 continued to stir and mix around the oatmeal, stopped, looked at the bowel then continued to stir the oatmeal but had not taken any food. At 7:57 a.m. R12 started to take a couple of bites of her oatmeal. At 8:03 a.m. R12 stopped eating and put her spoon down. At 8:04 a.m. a nursing assistant (NA)-A told R12, you pick your spoon up and eat then the NA left the area. R12 picked up her spoon and took a couple of bites. At 8:09 a.m. R12 stopped eating. Nursing assistant (NA)-B is now seated across the table from her assisting another resident to eat. NA-B was not encouraging R12 to eat. At 8:11 a.m. R12 started to take a couple bites on her own. At 8:16 a.m. R12 is not eating and is not being encouraged to eat by NA-B seated across the table from her. At 8:20 a.m. R12 continued to not eat or receive encouragement or assistance with her breakfast. At 8:22 a.m. the director of nursing (DON) approached the table and asked NA-B how long R12 had the bowl of oatmeal. NA-B stated he did not know. The DON told NA-B she was going to get R12 a new bowl of oatmeal and stated she was going to sit by her to keep her awake and	F 656	needs of the resident. R12's care plan was revised to reflect that she is to be fed if she is not eating. All residents care plans have been reviewed and updated with most current and up to date information. The updated care plans will be printed out for the nursing staff to reference. Updates will be made as residents needs changes and written on the care plan and then all updated information will be printed as needed. A copy of the changes made will be posted for nursing staff to reference to ensure all are aware of any changes. An audit of this process will be done weekly x 1 month then monthly for 90 days and as needed. Results of the audits will be discussed in QA. Random care audits will be completed and results of audits for identified areas of concern and need for continued education. The DON or designee will be responsible for compliance of audits.	

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assist her to eat. At 8:25 a.m. the DON returned to the table with a new bowl of oatmeal and is now sitting next to R12 and is encouraging her to eat. R12 started to eat bites of her oatmeal. At 8:26 a.m. the DON positioned R12 wheelchair closer to the table and directed NA-B to provide her encouragement with eating and the DON left the dining room. At 8:31 a.m. NA-B was not encouraging R12 to eat. At 8:33 a.m. NA-B stated R12's name two times. R12 is not eating and placed her spoon in her bowl. At 8:37 a.m. NA-B is now seated next to R12 to encourage her to eat. R12 was observed to start taking bites of her oatmeal.

R12's quarterly Minimum Data Set (MDS) dated 10/26/17, identified diagnoses of dementia. A brief interview for mental status (BIMS) score of 11 indicated moderate cognitive impairment and needed extensive assist of one staff member for eating.

R12's care plan included extensive assist of one for eating. Encourage her to eat on her own.

R12's Guidelines for Daily Cares included, extensive assist of one, encourage her to eat on her own.
R12 was interviewed on 11/28/17, at 3:44 p.m. in her room. R12 stated she sometimes she can feed herself but mostly somebody has been feeding me. R12 stated, 'I knows I eat more if somebody feeds me and stated sometimes I think I am lazy."

During an interview on 11/30/17, at 10:26 a.m. NA-A stated R12 can feed herself. NA-A stated if you are not sitting there feeding her, she will not eat even with cues, she will look at it and not try.

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F 656	Continued From page 9 NA-A stated R12 needed staff to feed her. During an interview on 12/1/17, at 1:56 p.m. the director of nursing (DON) stated R12 was seated at the table where supervision occurred and stated she expected the staff person at the table to be encouraging R12 to eat on her own and if she will not eat on her own with the encouragement staff should assist her to eat. The DON stated if a resident was served their food, and they have not attempted to start to feed themselves, staff should intervene and start to assist residents to eat within five minutes of the resident receiving their food. The DON stated residents should be brought into the dining room when there food was ready and staff were available to assist and feed the residents. The DON stated staff need more education on not bringing residents into the dining room until staff are able to assist residents to eat. The DON verified the care plan was not followed to provide R12 extensive assist of one during meals.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 679		1/12/18

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F 679	Continued From page 10 Based on observation, interview and record review, the facility failed to assess resident centered activities preferences for 2 of 2 residents (R9 & R18) who were reviewed for activities and develop interventions to meet their activity preferences based on the resident centered assessment then evaluate if activity preferences change. Findings include: R9 was observed on 11/28/17 at 1:40 p.m. after returning from noon meal. He was assisted by staff to toilet, then assisted to recliner. There was no music or TV offered and he sat in a dark room with curtains pulled. He was not offered to attend activities which was at 2:00 p.m. called Duck Cared Game. Nor was he taken to Social Hour offered at 3:00 p.m. At 5:05 p.m. he was assisted to walk to the dining room. At 6:13 p.m. he was taken back to his room and again curtains were closed and room was left dark, no music was offered. On 11/29/17 during activities offered at 11:00 a.m. Reading Corner, at 2:00 p.m. Cards, and at 3:30 p.m. R9 was in his room either in bed or in recliner with curtains closed, dark room, and no music offered. On 11/30/17 activities offered at 11:00 a.m. of exercises, at 2:00 p.m. Card Bingo and at 3:00 p.m. Social hour, again R7 had not attended any of these activities and was observed at 9:09 a.m. to have finished his breakfast then moved to his room. Care provided on return to room and was assisted to bed, her remained in bed until 11:20 a.m. when he was toileted then moved to dining room for lunch. At 2:07 p.m. he was observed in	F 679	It is the policy of OCR to ensure that all the needs of the residents activity preferences are reflected on their care plan to obtain the highest level of functions possible and to promote choices of desired activities. R# 7 and #9 had no ill effects of not attending activities. All current residents were assessed and asked about activity preferences. If the resident is unable to state their preferences a family interview will be conducted to identify past likes and dislikes the updated information will be added to the care plan. All new admission will be assessed upon admission. Staff will assist residents to preferred activities. If a resident chooses not to participate in daily programming another form of desired activity will be offered. Activity care plans will be reviewed weekly x 1 month the monthly x 90 days then quarterly thereafter. Results of audits will be brought to QA to review and determine if any other new interventions or areas of education are needed. The DON or designee will be responsible for compliance of the audits and care plan updates.	

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his room up in his w/c in room, again curtains closed, room dark. At 3:00 he was observed to be in day room with other residents however, his eyes were closed and even though the activity of Social Hour was held R7 did no activity engage in this activity.

R9's monthly attendance record for facility offered activities he attended for the months of September, October and November 2017:

September 2017: music, three times; Bingo, attended 3 times; barber, attended once; cards, attended 1 time; birthday party, attended once; exercises, attended once; reading, attended once; worship service, only once; visiting with others, none. No one to one completed.

October 2017: music, once; bingo, 8 times; cards, once; birthday party, twice; exercises, once; reading, once; worship service, none; and visiting with others, twice.

November 2017: music, 4 times; bingo, 8 times; cards, none; exercises, reading, worship service, visiting with others, all of these were not attended; party, once.

R9's comprehensive care plan for activities included a problem of attends most activities, goal is satisfied with level of social interaction, and approach includes nurses to identify underlying causes of decreased activity participation, assure adequate pain control, encourage family involvement and avoid interrupting activities for routine cares. Nursing Aides to invite and assist to activities, encourage activity participation, encourage reminiscence, offer conversation, report change in ability, toilet

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before activities.

R9's annual Minimum Data Set dated 1/5/17 identifies he is cognitively impaired, and according to the activity assessment he likes music and doing things with groups of people. Also finds favorite activities as being very important, however, there is no likes/dislikes screening completed to determine what favorite activities for R9 include. Also R9 like to go outside when the weather is good, this is very important to him.

During an interview with the director of activities on 12/1/17 at 9:19 a.m. it was learned that the only activity assessment completed for residents was from the Minimum Data Set. Also the activity director said she was told before she was hired they would assess activities likes/dislikes during each quarterly resident conference meeting.

During an interview on 12/01/17 at 1:53 p.m. with family member (FM)-A concerning activities R9 had done in the past. FM-A shared R9 was a farmer and liked being outside and socialized with other farmers. Also R9 liked certain TV shows but the TV in his room has been broken for the past two year. FM-A said he likes music and FM-A brought in a radio but was unable to get reception.

R18 was observed on 11/28/17 at 12:37 p.m. to have completed her lunch meal, She moved herself independently in the wheelchair to her room, where she rested in bed on her back. No music or TV on. At 4:06 p.m. R18 had remained in her room for the afternoon and did not attend the facility offered activity of Duck cards at 2:00 p.m. and Social hour at 3:00 p.m.

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 _____	12/04/2017

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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F 679	Continued From page 13	F 679		

During an interview with R18 on 11/29/17 at 8:45 a.m. regarding facility offered activities, R18 said they don't have much I like, I don't like Bingo, and sure would like more offered.

Review of R18's activity attendance for September 2017 included: Music, attended four times; beauty shop, once; birthday party, twice; visiting with others, once; workshop service, once; and nails/manicure, once. October 2017 included: beauty shop, three times; birthday party, three days; reading, once; nails/manicure, once. There were no activities from October 12 to 17, offered, and from October 19 to 29, 2017 offered. November 2017: beauty shop, four times; birthday part, once; party, once; music-singalong, once. There were no activities attended from November 12 to 21, 2017.

R18's annual Minimum Data Set dated 4/26/17 included R18 was cognitively intact, for activities felt activities of music, pets, keep current with news, favorite activities and going outside if weather ok, were very important. Activities of being with other people and participate in religious services were somewhat important.

R18's comprehensive care plan run date of 12/1/17 lacked any mention of favorite activities identified. Also the care plan included behaviors related to relationship with husband however, there is no intervention to include activities to meet her needs.

During an interview with the director of activities on 12/1/17 at 9:19 a.m. it was learned that the only activity assessment completed for residents was from the Minimum Data Set. Also the activity

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F 679	Continued From page 14 director said she was told before she was hired they would assess activities likes/dislikes during each quarterly resident conference meeting. Also the director of activities said R18 does not like going to activities as her husband does not like her to attend them. Review of November Calendar for activities offered by the facility included: Saturday offered social hour at 3:00 p.m. and Lawrence Welk at 6:00 p.m. ; Sunday is America's funniest videos at 6:00 p.m. and the first Sunday of month was Pastor at 2:00 p.m. Monday, Tuesday, Wednesday, Thursday and Friday offer activity at 11:00 a.m. reading corner or exercise, 2:00 p.m. Cards/bingo/music/worship time and 3:00 p.m. social hour each day. These were the only group activities offered to all resident to attend.	F 679		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		1/12/18

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F 883	Continued From page 15 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883		

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F 883	Continued From page 16 Based on interview and record review the facility failed to offer the pneumococcal Prevnar 13, timely for 3 of 5 residents (R7, R9 & R18) who were taken for immunization protocol. Findings include: R7 has been in the facility for over two years according to the face sheet, on reviewing the immunization record for R7 it included an entry dated 5/9/16 he had received PPSV23 on 9/4/12. On 12/1/17 there was an entry R7 had received Prevnar-13 which was completed after this surveyor queried staff on the status of the Prevnar-13. R7's physician (P)-A wrote an order dated 10/6/17 to give Prevnar-13, however, it had not been given until 12/1/17. R9 had been in the facility for over two years according to the face sheet, on reviewing the immunization record for R9, it included an entry dated 2/17/15 to have had received pneumococcal polysaccharide vaccine (PPSV23) (Pneumovax medication) vaccination 9/24/02. The Prevnar-13 had been given on 12/1/17 which was after this surveyor queried staff on the status of Prevnar-13. R9's P-A wrote an order dated 10/6/17 to give Prevnar 13, however, it had not been given until 12/1/17. R18 has been admitted two years ago according to the face sheet, and on reviewing the immunization record for R18, it included an entry dated 8/20/15 to have received PPSV23. The Prevnar-13 was given on 12/1/17 after this	F 883	It is the policy of OCR to ensure that current residents and all new residents are offered influenza and pneumococcal immunizations as needed. Res #7,9,& 18 had no ill effects of not receiving the vaccines at the time they were ordered by the physician or delivery into the facility. All residents MAR/TAR's have been reviewed to ensure that all are up to date. Any new residents of the facility that is admitted after 12/4/17 will be offered influenza and pneumococcal if needed. Any new residents admitted will have a record review 2 days after admission to ensure immunizations are current. We will offer any needed immunizations at that time. This information will be discussed in QA during the influenza season. The DON or designee will be responsible to ensure compliance of immunizations.	

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F 883	Continued From page 17 surveyor queried about the status of Prevnar-13. R18's P-A wrote an order dated 10/6/17 to give Prevnar 13, however, it had not been done until 12/1/17. On 11/30/17 1:04 p.m. during an interview with licensed practical nurse (LPN)-C regarding Prevnar-13 vials located in medication refrigerator, that R7, R9 & R18 had not received the Prevnar 13 medication at this time. LPN-C said it should have been given but for some reason there was a delay. On 12/01/17 at 9:16 a.m. during an interview with the director of nursing it was found that R7, R9, & R18 had not had the Prevnar-13 until today.	F 883		

Electronically delivered
December 18, 2017

Ms. Janice Howe, Administrator
Ostrander Care And Rehabilitation
305 Minnesota Street
Ostrander, MN 55961

Re: State Nursing Home Licensing Orders - Project Number S5464029

Dear Ms. Howe:

The above facility was surveyed on November 28, 2017 through December 4, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731 or at gary.nederhoff@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00922	A. BUILDING: _____ B. WING _____	12/04/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 28, 29, 30, December 1 & 4, 2017 , surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently implement the care plan regarding extensive assist of one with eating for 1 of 1 residents (R12) who had been reviewed for nutritional status. Findings include: R12 was observed on 11/28/17, at 6:17 p.m. R12 had food placed in front of her and was observed to not be eating. Registered nurse (RN)-A was asked the length of time the food had placed in front of R12. RN-A stated about an hour, or maybe 45 minutes. A staff member than sat down to assist R12 to eat. R12 told the staff member her potatoes were cold. R12 was observed during breakfast on 11/30/17, at 7:40 a.m. R12 was served oatmeal, apple juice and milk. At 7:44 a.m. R12 was stirring the oatmeal but not eating. At 7:48 a.m. R12	2 565	Corrected	1/12/18

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2 565	Continued From page 3	2 565		

continued to stir and mix around the oatmeal, stopped, looked at the bowel then continued to stir the oatmeal but had not taken any food. At 7:57 a.m. R12 started to take a couple of bites of her oatmeal. At 8:03 a.m. R12 stopped eating and put her spoon down. At 8:04 a.m. a nursing assistant (NA)-A told R12, you pick your spoon up and eat then the NA left the area. R12 picked up her spoon and took a couple of bites. At 8:09 a.m. R12 stopped eating. Nursing assistant (NA)-B is now seated across the table from her assisting another resident to eat. NA-B was not encouraging R12 to eat. At 8:11 a.m. R12 started to take a couple bites on her own. At 8:16 a.m. R12 is not eating and is not being encouraged to eat by NA-B seated across the table from her. At 8:20 a.m. R12 continued to not eat or receive encouragement or assistance with her breakfast. At 8:22 a.m. the director of nursing (DON) approached the table and asked NA-B how long R12 had the bowl of oatmeal. NA-B stated he did not know. The DON told NA-B she was going to get R12 a new bowl of oatmeal and stated she was going to sit by her to keep her awake and assist her to eat. At 8:25 a.m. the DON returned to the table with a new bowl of oatmeal and is now sitting next to R12 and is encouraging her to eat. R12 started to eat bites of her oatmeal. At 8:26 a.m. the DON positioned R12 wheelchair closer to the table and directed NA-B to provide her encouragement with eating and the DON left the dining room. At 8:31 a.m. NA-B was not encouraging R12 to eat. At 8:33 a.m. NA-B stated R12's name two times. R12 is not eating and placed her spoon in her bowl. At 8:37 a.m. NA-B is now seated next to R12 to encourage her to eat. R12 was observed to start taking bites of her oatmeal.

R12's quarterly Minimum Data Set (MDS) dated

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2 565	Continued From page 4 10/26/17, identified diagnoses of dementia. A brief interview for mental status (BIMS) score of 11 indicated moderate cognitive impairment and needed extensive assist of one staff member for eating. R12's care plan included extensive assist of one for eating. Encourage her to eat on her own. R12's Guidelines for Daily Cares included, extensive assist of one, encourage her to eat on her own. R12 was interviewed on 11/28/17, at 3:44 p.m. in her room. R12 stated she sometimes she can feed herself but mostly somebody has been feeding me. R12 stated, 'I knows I eat more if somebody feeds me and stated sometimes I think I am lazy." During an interview on 11/30/17, at 10:26 a.m. NA-A stated R12 can feed herself. NA-A stated if you are not sitting there feeding her, she will not eat even with cues, she will look at it and not try. NA-A stated R12 needed staff to feed her. During an interview on 12/1/17, at 1:56 p.m. the director of nursing (DON) stated R12 was seated at the table where supervision occurred and stated she expected the staff person at the table to be encouraging R12 to eat on her own and if she will not eat on her own with the encouragement staff should assist her to eat. The DON stated if a resident was served their food, and they have not attempted to start to feed themselves, staff should intervene and start to assist residents to eat within five minutes of the resident receiving their food. The DON stated residents should be brought into the dining room when there food was ready and staff were available to assist and feed the residents. The	2 565		

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2 565	Continued From page 5 DON stated staff need more education on not bringing residents into the dining room until staff are able to assist residents to eat. The DON verified the care plan was not followed to provide R12 extensive assist of one during meals. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service employees responsible for providing assessed and care planned interventions to meet the needs of the residents as identified in the comprehensive care plan. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as	21390		1/12/18

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(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) COMPLETE DATE
21390	Continued From page 6 defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to offer the pneumococcal Prevnar 13, timely for 3 of 5 residents (R7, R9 & R18) who were taken for immunization protocol. Findings include: R7 has been in the facility for over two years according to the face sheet, on reviewing the immunization record for R7 it included an entry dated 5/9/16 he had received PPSV23 on 9/4/12. On 12/1/17 there was an entry R7 had received Prevnar-13 which was completed after this surveyor queried staff on the status of the Prevnar-13. R7's physician (P)-A wrote an order dated 10/6/17 to give Prevnar-13, however, it had not been given until 12/1/17. R9 had been in the facility for over two years according to the face sheet, on reviewing the immunization record for R9, it included an entry dated 2/17/15 to have had received pneumococcal polysaccharide vaccine (PPSV23) (Pneumovax medication) vaccination 9/24/02. The Prevnar-13 had been given on 12/1/17 which was after this surveyor queried staff on the status	21390	Corrected	

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21390	Continued From page 7 of Prevnar-13. R9's P-A wrote an order dated 10/6/17 to give Prevnar 13, however, it had not been given until 12/1/17. R18 has been admitted two years ago according to the face sheet, and on reviewing the immunization record for R18, it included an entry dated 8/20/15 to have received PPSV23. The Prevnar-13 was given on 12/1/17 after this surveyor queried about the status of Prevnar-13. R18's P-A wrote an order dated 10/6/17 to give Prevnar 13, however, it had not been done until 12/1/17. On 11/30/17 1:04 p.m. during an interview with licensed practical nurse (LPN)-C regarding Prevnar-13 vials located in medication refrigerator, that R7, R9 & R18 had not received the Prevnar 13 medication at this time. LPN-C said it should have been given but for some reason there was a delay. On 12/01/17 at 9:16 a.m. during an interview with the director of nursing it was found that R7, R9, & R18 had not had the Prevnar-13 until today. SUGGESTED METHOD OF CORRECTION: The physician or director of nursing could in-service the responsible person who is designated to maintain a current up to date immunizations as directed by the centers for disease control. Also to monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		

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21426	Continued From page 8	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility tuberculosis (TB) risk assessment was completed, 5 of 5 employees (E1, E2, E3, E4, and E5) who did not receive monitoring for TB per Center for Disease Control and Prevention (CDC) guidelines and for 5 of 5 residents (R21, R40, R41, R42 and R5) who did not receive TB risk assessment screening and did not receive monitoring for TB per CDC guidelines. This had the potential to affect all clients, staff, and visitors entering the	21426	Corrected	1/12/18

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21426	Continued From page 9 facility. Findings include: E1 hired 3/10/17, first step was administered 3/10/17, same day as start day with no results of the first step being read and no second step administered. E2 hired 5/23/17, first step was given 6/26/17, 23 days after started. The second step given 7/3/17, five days after the first step results. Two days earlier than required. E3 hired 10/2/17, first step given 10/10/17, eight days after started. E4 hired 11/13/17, first step given 11/17/17, four days after started. The second step given 11/24/17, five days after the first step results. Two days earlier than required. E5 hired 11/21/17, first step given 11/22/17, one day after started. R21, R40, R41, R 42 or R5 had a TB risk assessment screening completed on hire. R21 admitted on 10/23/17, first step administered 10/25/17, second step administered 10/31/17, two days earlier than required. R40 admitted 2/27/17, first step administered 3/3/17, one day after required. No second given. R41 admitted 8/3/17, first step administered 8/4/17, second step given 8/11/17, five days after the first step results. Two days earlier than required.	21426		

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21426	Continued From page 10 R42 admitted 9/26/17, first step administered 9/26/17, second step given 10/3/17, five days after the first step results. Two days earlier than required. R5 admitted 6/19/17, first step given 6/26/17, four days after required. No second step administered. Requested a copy of the most recent facility risk assessment, none provided. Interview with Director of Nursing (DON) on 12/01/17, at 9:43 a.m. verified no screening of TB had been completed for the residents. On 12/4/17, at 2:02 p.m. DON verified the staff do not have a waiting period and TB testing given the same day as the employees start working with the residents. DON stated the expectation would be to follow policy and procedure and given to employees before starting on the floor. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review current CDC guidelines for tuberculosis control within health care facilities and complete ongoing monitoring of new admissions and employees to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be	21435		1/12/18

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21435	Continued From page 11 based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess resident centered activities preferences for 2 of 2 residents (R9 & R18) who were reviewed for activities and develop interventions to meet their activity preferences based on the resident centered assessment then evaluate if activity preferences change. Findings include: R9 was observed on 11/28/17 at 1:40 p.m. after returning from noon meal. He was assisted by staff to toilet, then assisted to recliner. There was no music or TV offered and he sat in a dark room with curtains pulled. He was not offered to attend activities which was at 2:00 p.m. called Duck Cared Game. Nor was he taken to Social Hour offered at 3:00 p.m. At 5:05 p.m. he was assisted to walk to the dining room. At 6:13 p.m. he was taken back to his room and again curtains were closed and room was left dark, no music was offered. On 11/29/17 during activities offered at 11:00 a.m. Reading Corner, at 2:00 p.m. Cards, and at 3:30	21435	Corrected	

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21435	Continued From page 12 p.m. R9 was in his room either in bed or in recliner with curtains closed, dark room, and no music offered. On 11/30/17 activities offered at 11:00 a.m. of exercises, at 2:00 p.m. Card Bingo and at 3:00 p.m. Social hour, again R7 had not attended any of these activities and was observed at 9:09 a.m. to have finished his breakfast then moved to his room. Care provided on return to room and was assisted to bed, her remained in bed until 11:20 a.m. when he was toileted then moved to dining room for lunch. At 2:07 p.m. he was observed in his room up in his w/c in room, again curtains closed, room dark. At 3:00 he was observed to be in day room with other residents however, his eyes were closed and even though the activity of Social Hour was held R7 did no activity engage in this activity. R9's monthly attendance record for facility offered activities he attended for the months of September, October and November 2017: September 2017: music, three times; Bingo, attended 3 times; barber, attended once; cards, attended 1 time; birthday party, attended once; exercises, attended once; reading, attended once; worship service, only once; visiting with others, none. No one to one completed. October 2017: music, once; bingo, 8 times; cards, once; birthday party, twice; exercises, once; reading, once; worship service, none; and visiting with others, twice. November 2017: music, 4 times; bingo, 8 times; cards, none; exercises, reading, worship service, visiting with others, all of these were not attended; party, once.	21435		

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21435	Continued From page 13 R9's comprehensive care plan for activities included a problem of attends most activities, goal is satisfied with level of social interaction, and approach includes nurses to identify underlying causes of decreased activity participation, assure adequate pain control, encourage family involvement and avoid interrupting activities for routine cares. Nursing Aides to invite and assist to activities, encourage activity participation, encourage reminiscence, offer conversation, report change in ability, toilet before activities. R9's annual Minimum Data Set dated 1/5/17 identifies he is cognitively impaired, and according to the activity assessment he likes music and doing things with groups of people. Also finds favorite activities as being very important, however, there is no likes/dislikes screening completed to determine what favorite activities for R9 include. Also R9 like to go outside when the weather is good, this is very important to him. During an interview with the director of activities on 12/1/17 at 9:19 a.m. it was learned that the only activity assessment completed for residents was from the Minimum Data Set. Also the activity director said she was told before she was hired they would assess activities likes/dislikes during each quarterly resident conference meeting. During an interview on 12/01/17 at 1:53 p.m. with family member (FM)-A concerning activities R9 had done in the past. FM-A shared R9 was a farmer and liked being outside and socialized with other farmers. Also R9 liked certain TV shows but the TV in his room has been broken for the past two year. FM-A said he likes music and FM-A	21435		

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21435	Continued From page 14	21435		

brought in a radio but was unable to get reception.

R18 was observed on 11/28/17 at 12:37 p.m. to have completed her lunch meal, She moved herself independently in the wheelchair to her room, where she rested in bed on her back. No music or TV on. At 4:06 p.m. R18 had remained in her room for the afternoon and did not attend the facility offered activity of Duck cards at 2:00 p.m. and Social hour at 3:00 p.m.

During an interview with R18 on 11/29/17 at 8:45 a.m. regarding facility offered activities, R18 said they don't have much I like, I don't like Bingo, and sure would like more offered.

Review of R18's activity attendance for September 2017 included: Music, attended four times; beauty shop, once; birthday party, twice; visiting with others, once; workshop service, once; and nails/manicure, once. October 2017 included: beauty shop, three times; birthday party, three days; reading, once; nails/manicure, once. There were no activities from October 12 to 17, offered, and from October 19 to 29, 2017 offered. November 2017: beauty shop, four times; birthday part, once; party, once; music-singalong, once. There were no activities attended from November 12 to 21, 2017.

R18's annual Minimum Data Set dated 4/26/17 included R18 was cognitively intact, for activities felt activities of music, pets, keep current with news, favorite activities and going outside if weather ok, were very important. Activities of being with other people and participate in religious services were somewhat important.

R18's comprehensive care plan run date of

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21435	Continued From page 15 12/1/17 lacked any mention of favorite activities identified. Also the care plan included behaviors related to relationship with husband however, there is no intervention to include activities to meet her needs. During an interview with the director of activities on 12/1/17 at 9:19 a.m. it was learned that the only activity assessment completed for residents was from the Minimum Data Set. Also the activity director said she was told before she was hired they would assess activities likes/dislikes during each quarterly resident conference meeting. Also the director of activities said R18 does not like going to activities as her husband does not like her to attend them. Review of November Calendar for activities offered by the facility included: Saturday offered social hour at 3:00 p.m. and Lawrence Welk at 6:00 p.m. ; Sunday is America's funniest videos at 6:00 p.m. and the first Sunday of month was Pastor at 2:00 p.m. Monday, Tuesday, Wednesday, Thursday and Friday offer activity at 11:00 a.m. reading corner or exercise, 2:00 p.m. Cards/bingo/music/worship time and 3:00 p.m. social hour each day. These were the only group activities offered to all resident to attend. SUGGESTED METHOD OF CORRECTION: The activity director could complete an individualized resident assessment to determine resident centered activities then develop interventions to meet these needs. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		

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21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview the facility failed to maintain a dignified atmosphere for 2 of 2 residents (R3 & R14)who require assistance with eating was observed in the dining room waiting for meals to be served while others in the dining room were receiving their food. R3 admitted 12/14/14, according to face sheet with diagnosis of unspecified dementia without with behavioral disturbance who is dependent on staff to eat. Observed R3 on 11/28/17, at 6:00 p.m. in the dining room served pureed meat, scalloped corn and magic cup (nutritional supplement.) R3 been observed to be seated at the dining room table since 5:00 p.m. Observation on 11/30/17, at 7:14 a.m. R3 sitting at the dining table, clothes protector on, sleeping with head tipped down. Noted no food in front of her, no nursing staff in the dining room. Interviewed dietary aide (DA)-A, how long has R3 been in dining room. DA-A stated about half hour and we cannot put food out because she needed help to eat. At 8:13 a.m. R3 was served food. At 8:30 a.m. No attempts by staff to assist R3 to eat her meal. At 8:38 a.m. Director of Nursing (DON)	21805	Corrected	1/12/18

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21805	Continued From page 17	21805		

came in dining room requested a magic cup and started to assist R3 to eat. At 8:40 a.m. DON requested drinks for R3 and assisted her to drink some. At 9:27 a.m. R3 continued to sit at dining room table assisted by staff to continue to eat her meal.

R14 admitted 10/1/09, according to face sheet, with type 2 diabetes mellitus without complications requires assistance and cueing from staff to eat.

On 11/28/17 at 6:12 p.m. R14 sitting in the dining room at the table and was served pureed meat, scalloped corn and given a magic cup (nutritional supplement). R14 was previously observed to be sitting at the table in the dining room before 5:00 p.m. with no staff present.

On 11/30/17 at 7:15 a.m. sitting in the dining room eyes closed, moving around in her chair. At 8:05 a.m. R14 continue to sit in the dining room with no staff interaction or food. At 8:13 a.m. R14 had been served food, staff sitting next to R14 while R14 holding on to her glass and drinking self. R14 waited from 7:15 a.m. to 8:13 a.m. for food and assistance to eat while others in dining room were served/eating meal.

Interview with DON on 12/01/17, at 1:57 p.m. Expectation for dependent residents would be to have staff available when food is ready. DON expectation regarding placing residents at the dining table for an extended time when no food can be served, DON stated that no resident should be placed at the table until food is ready to be served and staff available to assist them eat.

On 12/04/17, at 1:10 p.m. surveyor requested information on the dignity and dining observation

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21805	Continued From page 18 policies and procedures. DON stated they do not have a policy on dignity or proper dining observation, stated it is a standard of care; no resident should be left in the dining room staring at nothing. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual need of each resident discussed above. It could also address other residents that may be at risk for the same concern. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or	21855		1/12/18

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21855	Continued From page 19 assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain confidentiality for 1 of 1 resident (R15) health status was announced and heard by staff and visitors located in hallway by residents room. Findings include: During an observation on 11/30/17, at 2:20 p.m. Surveyor was sitting at the nurses station when licensed practical nurse (LPN)-B loudly called out to another LPN-A down the hallway while walking by the nurses station. LPN-B was easily heard saying in regards to R15, "Just wanted to let you know [R15] fell about 15 minutes ago, I am taking her to go get vitals and blood sugar." On 11/30/17 at 2:30 p.m. during an interview with R15 concerning her fall, LPN-B was in the areas and said, "I should not have called it out in the halls [regarding her health status]. I made a mistake." Interview on 11/30/17 at 2:47 p.m. with director of nursing (DON) and administrator was asked their expectation about maintaining and environment of confidentiality with resident cares/health status. Both the DON and administrator said this should not have happened. They continued to say that the LPN should have taken the other LPN aside and informed of the fall. The DON handed the confidentially policy and HIPAA information to surveyor and said the information is gone through on hire. The Policy	21855	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00922	A. BUILDING: _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21855	Continued From page 20 titled, Confidentiality Policy reads: to protect and maintain confidentiality of health care and other private information of the residents. Also an employee handbook was provided and on page 20 it reads: under confidentiality/HIPAA; all employees have a special obligation to maintain the security of information that is entrusted to them. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train staff to ensure the personal privacy of residents, and then perform audits to ensure each resident's right to privacy is maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		

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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2017**

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OSTRANDER CARE AND REHAB	**305 MINNESOTA STREET** **OSTRANDER, MN 55961**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/2017

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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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2017**

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K 000	Continued From page 1 Angela.Kappenman@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 & Rehab) is a 1 1/2-story building with a partial basement. The original building was constructed in 1968 and was determined to be of Type II(222) construction and meets the construction type allowed for existing buildings. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 20 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration	K 291		1/12/18

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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2017**

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K 291	Continued From page 2 is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17, based on documentation review and interview that the following include: The Facility does not have a record of Emergency lighting unit being tested last on 12-2016. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	It is the policy of OCR to monitor emergency lighting on a monthly basis. The policy was reviewed and updated to meet the current regulations. A spreadsheet was developed and placed in the Life Safety Code Documentation Manual. The maintenance director will monitor monthly and document appropriately.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324		1/12/18

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K 324	Continued From page 3 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324	Kitchen hood was inspected 6/26/17 and is scheduled to be inspected on 12/26/17 by Summit. It is the policy of Care and Rehab to have the kitchen hood inspected every 6 months. The NHA will be responsible fro compliance of the hood inspection and the timeliness of the schedule.	

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K 324	Continued From page 4 Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17, based on documentation review and interview that the following include: The Facility does not have a record of the last 6 month test on kitchen hood system. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 324		
K 346 SS=D	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	K 346	It is the policy of OCR to properly notify the appropriate parties when the system is out of service for more than 4 hours in 24 hours. The Fire Alarm-Out of Service Policy was revised and updated to most current information. This information will be reviewed by the safety committee quarterly and changes will be made as needed.	1/12/18

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K 346	Continued From page 5 Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17,based on documentation review and interview that the following include: Facility does not have documentation of Fire Alarm out of service plan. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 346		
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are	K 354	It is the policy of OCR to properly notify the appropriate parties when the system is out of service for more than 10 hours in 24 hours. The Fire Alarm/Sprinkler-Out of	1/12/18

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K 354	Continued From page 6 inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17,based on documentation review and interview that the following include: Facility does not have documentation of Fire Sprinkler system out of service plan. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 354	Service Policy was revised and updated to most current information. This information will be reviewed by the safety committee quarterly and changes will be made as needed.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372		1/12/18

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K 372	Continued From page 7 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17, based on observation and interview revealed that the following include: Penetrations were found above ceiling in smoke barrier around pipes on main floor. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372	It is the policy of OCR to maintain appropriate smoke barriers to all atrium walls. Penetrations found above the ceiling were repaired 12/22/2017. Maintenance Personnel will monitor smoke barriers monthly to ensure all penetrations have been repaired, or if any new penetrations have occurred to be repaired immediately.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101	K 711		1/12/18

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K 711	Continued From page 8 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17, based on documentation review and interview that the following include: The Facility does not have a current Fire safety plan	K 711	Policy was obtained from our OCR Safety Disaster Preparedness Manual and was reviewed and updated and placed in the Life Safety code Documentation Manual. All information has been updated to the 2012 version. Policies and Procedures were developed based on the needs of the facility. Information will be reviewed and updated at each quarterly safety meeting.	

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K 711	Continued From page 9 This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 711		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used	K 712	The deficient practice was identified in July 2017 and a Process Improvement Plan was put into place to ensure testing was being completed. A schedule of fire drills was developed through the rest of 2017. Regular fire drills have been completed at unexpected times and varying conditions at least quarterly on each shift. NHA will be responsible to ensure that fire drills are completed on schedule set forth and will be reviewed at the quarterly	1/12/18

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K 712	Continued From page 10 instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17, based on documentation review and interview that the following include: The Facility is missing fire drills for month's Jan, Feb, April, May, July of 2017. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	safety meeting.	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply	K 741		1/12/18

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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2017**

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 741	Continued From page 11 where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Findings Include:	K 741	The no smoking sign was removed and replaced with Designated Smoking Area and metal receptacle remains in place.	

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K 741	Continued From page 12 On facility tour between 10:00 AM and 0100 PM on 11/30/17, based on observation and interview revealed that the following include: Found a smoke area on 2nd floor outside on roof being used as a smoking area with sign-age posted NO SMOKING. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 741		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901	The facility risk assessment was completed prior to the 11/28/17 by facility personnel. A copy of this was placed in the facility Life Safety Code Documentation Manual. This copy was also give to the State Surveys during our annual survey. Risk Assessment will be	1/12/18

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K 901	Continued From page 13 Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17, based on documentation review and interview that the following include: The Facility has not completed a Risk Assessment of the facility. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 901	reviewed and updated as needed.	
K 912 SS=F	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed	K 912	It is the policy of OCR to monitor and maintain electrical receptacles in accordance with the regulations. A policy and monthly checklist was developed and updated and placed in the Life Safety Code Documentation Manual. It will be reviewed and updated as needed.	1/12/18

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K 912	Continued From page 14 tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17, based on documentation review and interview that the following include: The Facility has not completed their electrical receptacle testing. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 912		
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	K 923		1/12/18

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K 923	Continued From page 15 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 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: 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	K 923	It is the policy of OCR to maintain oxygen storage where empty tanks are segregated from full tanks. OCR will designate only one company to supply oxygen to the facility. One room will be designated as full cylinders and one will be designated empty cylinders. The Maintenance Director will monitor monthly to ensure that all cylinders are properly stored.	

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K 923	Continued From page 16 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 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) Findings Include: On facility tour between 10:00 AM and 01:00 PM on 11/30/17, based on observation and interview revealed that the following include: We found O2 cylinder that are mixed with full and empty in three different rooms. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartments. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923		