DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 1, 2022

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

RE: CCN: 245464
Cycle Start Date: June 30, 2022

Dear Administrator:

On August 17, 2022, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 1, 2022

CMS Certification Number (CCN): 245464

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

Dear Administrator:

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

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

Effective August 5, 2022 the above facility is certified for:

25 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

Electronically delivered
July 19, 2022

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

RE: CCN: 245464
Cycle Start Date: June 30, 2022

Dear Administrator:

On June 30, 2022, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 30, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 30, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245464	A. BUILDING _____ B. WING _____	C 06/30/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 6/27/22 through 6/30/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents	E 000		
F 000	INITIAL COMMENTS On 6/27/22 through 6/30/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5464024C (MN81881), H5464025C (MN79947). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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

Electronically Signed | 07/29/2022

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 000	Continued From page 1 regulations has been attained.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by:	F 553		8/5/22

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F 553	Continued From page 2 Based on interviews and record reviews, facility failed to provide an opportunity for 2 of 2 residents (R10 & R12) to participate in a formal care conference to facilitate person centered care planning. Findings include: According to R10's Quarterly Minimum Data Set (MDS) assessment dated 5/17/22, R10 was cognitively intact and had diagnosis of diabetes mellitus, renal insufficiency post kidney transplant, anxiety and depression among other co-morbidities. When interviewed on 6/27/22, at 3:04 p.m. R10 stated he could not recall ever having been invited to a care conference (CC). He said he would go to resident council meetings, but had not been to a personal meeting regarding his care that he could recall. During the interview, R10 discussed various concerns about his medical care, his medications, the facility physician, his transplant team and coordination of care; as well as, his diet, the facility provided foods, activities, care of personal items and a wish to live in a different facility. R10 stated it was possible the facility had contacted his wife, but he had not received any notification that a CC was to be held and would like to have had. When interviewed on 6/29/22, at 10:03 a.m. the director of nursing (DON) stated she had a form that she filled out when any resident's quarterly MDS was due, and generally most of their CCs were a simple phone conversation going over that form. The DON stated the paper form was then scanned in to the resident's chart. When asked the DON was unable to locate documentation in	F 553	F553-Right to Participate in Planning Care-Care Conference. It is the policy of the facility to establish an individualized, comprehensive Care Plan for each resident within established guidelines of Federal and State regulations. The individualized comprehensive Care Plan will have a plan of care and create goals specified for the resident to reach and maintain the highest level of physical, mental and psychosocial function possible. The resident will be assessed upon admission and through nursing assessment the initial care plan will be developed. Residents/representative has the right to participate in care planning and shall be consulted about care and treatment changes. In regards to residents # 10 & 12 care conference was completed with the resident. The care conference form was reviewed with the resident, signed off, and scanned into the resident EMR. All other residents care conference was audited and scheduled for review with upcoming MDS schedule. Care Conference are to be scheduled in PCC according to Federal Regulations, The DON shall provide a copy of the Care Conference schedule to the Activity Director and or/ Social Worker (if available or designee) and Dietary Manager who are members of the IDCT. Activity Director will invite the resident and [or representative to the Care Conference, via letter, phone or in person. The Activity	

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F 553	Continued From page 3 R10's chart that a CC had occurred. DON was not able to say if R10 had been invited to a CC and did not know, "without any record" if a CC had been held for him since his admission approximately a year ago. DON stated this was "not acceptable." According to R12's 5 day admission MDS dated 5/14/22 (a readmission after hospitalization), R12 was cognitively intact and included diagnosis of cancer, diabetes, heart failure, bipolar mental illness, renal issues and neuropathy. When interviewed on 6/28/22, at 11:11 a.m. R12 stated he was frustrated as he had not been feeling well. R12 said he felt like he was "going backwards." R12 stated he was unsure what the facility was doing to help him with his health conditions. He expressed frustration that he was not receiving therapy, and he was unsure why that was. R12 stated he could not recall attending a care conference. When interviewed on 6/29/22, at 10:08 a.m. the DON stated she was not able to find evidence of any CC notes for R12 upon review of the chart. To prepare for CC, DON stated she gathered input from members of the interdisciplinary team (IDT), but a CC was generally completed by the DON alone. DON stated she was the social service designee for the facility. DON stated records of a CC should be accessible. A facility policy titled Care Planning, dated January 2013, indicated "The Administrator is the Care Plan/ MDS Coordinator. She sets up the schedule in PCC [Point Click Care, the facility electronic health record platform] for both according to Federal Regulations. 2. The Director	F 553	Director will make an attempt to schedule care conference at the best time of day for resident and representative. At the Care Conference resident/representative will be asked whether they have brought questions or concerns to the attention of facility staff. The Activity Director shall maintain a record of who has been invited, who declines to attend, who fails to respond to the invitation and who actually attends. The resident/representative attendance shall be recorded. In the absence of the Activity Director, the dietary Manager will schedule the Care Conferences and in their absence the DON will send invites. All members of IDCT were updated on expectations and Policy/Procedure reviewed and updated. This was completed on 7/05/2022 Audits will be completed weekly x 4 and monthly x3 and ongoing as needed. The results of these audits will be reported to the QAPI committee for further review and documentation.	

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F 553	Continued From page 4 of Nursing shall provide a copy of the Care Planning schedule to the Dietary Manager and Activity Director and/or Social Worker (if available), who are members of the IDCT. 3. The Activity Director shall invite the resident and/or appropriate family member to the care conference via letter, phone, or in person. 4. The Activity Director will make an attempt to schedule care planning conferences at the best time of the day for residents and families. 5. At the Care Plan Conference residents and family member will be asked whether they have brought questions or concerns to the attention of facility staff. 6. The Activity Director shall maintain a record of who has been invited, who declines to attend, who fails to respond to the invitation, and who actually attends. 7.Family/resident attendance shall be documented on the Care Plan. 8. In the absence of the Activity Director, the Dietary Manager will schedule the Care Plan Conferences. And in the absence of the Dietary Manager the DON will issue the invites."	F 553		
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.	F 583		8/5/22

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F 583	Continued From page 5 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the 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 document review, the facility failed to ensure resident right to personal privacy for 1 of 1 resident (R3) when staff enter residents room during provision of dressing change cares, fully exposing resident buttocks. Findings include: R3's quarterly Minimum Data Set (MDS) assessment dated 3/19/22, indicated R3 had moderate impaired cognition and required extensive assistance from 2 staff with bed mobility, dressing, and personal hygiene. The MDS also indicated R3 had impairment of both upper and lower extremities. R3's diagnosis list	F 583	F583/483.10-Personal Privacy/Confidentiality-includes accommodations, medical treatment, facility must respect the residents right to personal privacy. It is the policy of the facility to provide privacy for all residents while but not limited to personal cares and treatments, following all State and Federal regulations. In regards to resident #3 portable privacy curtain placed in residents' room for use during the personal cares and treatments. It is an expectation of this facility to knock on resident's door and wait for verbal response before entering.	

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F 583	Continued From page 6 included schizophrenia (a brain disorder affecting thinking and feeling), depression (mood disorder), generalized muscle weakness, morbid obesity, rhabdomyolysis (disorder causing muscle breakdown), stage 3-4 pressure ulcers to lower back and buttocks. During an observation, on 6/29/22 at 10:00 a.m., while staff were providing dressing changes to R3's lower back and buttocks; housekeeping (HSKP)-A, opened R3's door to room wide without knocking. HSKP-A asked staff present in R3's room to hand her R3's water pitcher for re-filling. At time of R3's opened room door, surveyor observed R3's neighboring resident looking towards R3's open doorway; R3 was lying on stomach in bed, buttocks fully exposed. During an interview, on 6/29/22 at 1:00 p.m., HSKP-A was asked about proper procedure when entering resident room doors, HSKP-A indicated proper procedure to include knocking on resident door and wait for response to come in. When HSKP-A was asked why she did not knock prior to entering R3's room, HSKP-A indicated she typically does knock on resident room doors prior to entering, was in a hurry to refill all resident room water-pitchers. HSKP-A did confirm that R3's privacy was compromised by opening room door wide and coming in unannounced. HSKP-A stated in future, would knock on door, wait for response to come in. When interviewed, on 6/30/22 at 11:21 a.m., licensed practical nurse (LPN)-A indicated awareness of 6/29/22 incident and R3's right to privacy being compromised. LPN-A stated while she was completing dressing changes to R3's buttocks; HSKP-A opened door to R3's room to	F 583	All residents will have privacy upheld at all times; staff will knock on resident doors, pause to wait for recognition before entering resident room. Staff involved immediately re-educated on residents' rights for privacy. Medical provider and family notified of breach. Portable privacy curtain placed in residents' room for during the personal cares and treatments. It is an expectation of this facility to knock on resident's door and wait for verbal response before entering. Policy & Procedure updated, staff educated on policy change and expectations on 7/01/22. Care Plan updated. Permanent Privacy curtain has been ordered. Audits will be completed weekly x 4 and monthly x3 and ongoing as needed. The results of these audits will be reported to the QAPI committee for further review and recommendations.	

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F 583	Continued From page 7 get water-pitcher for refilling. LPN-A confirmed HSKP-A opened door wide to R3's, exposed buttocks. LPN-A stated all residents' rooms are private without privacy curtains, resident's privacy can be compromised if performing cares or procedures when opening resident doors. LPN-A indicated all staff should knock and wait for response before opening doors to enter resident rooms. During an interview, on 6/30/22 12:38 p.m., the director of nursing (DON), indicated awareness of 6/29/22 incident and R3's right to privacy being compromised. The DON indicated she was not sure of current plan in place to ensure resident privacy if resident room doors are opened and cares or procedures are being performed on resident at that time. The DON stated it was her expectation all staff should be knocking on resident room doors and waiting for response prior to entering. A facility policy, titled "Combined Federal and State Bill of Rights, for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities;" revised date 6/18/19, included a section identified as Privacy and Confidentiality and consisted of; the resident has a right to personal privacy and confidentiality, personal privacy includes personal care, facility staff shall respect the privacy of a resident's room by knocking on their door and seeking consent before entering except in an emergency or where clearly inadvisable.	F 583		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		8/5/22

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F 688	Continued From page 8 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement and follow therapy intiated programs for 2 of 3 residents (R3, R12) who required range of motion, the use of a splint and walking programs maintain their activities of daily living. Findings include: R3's quarterly Minimum Data Set (MDS) assessment, dated 3/19/22; indicated R3 had moderately impaired cognition and functional limitations in activities of daily living (ADL). MDS also identified bilateral hand contractures, and required extensive assistance with bed mobility, transferring, dressing, personal hygiene, toileting, eating. R3 did not ambulate. The MDS further indicated diagnosis including rhabdomyolysis (breakdown of muscle tissue), repeated falls,	F 688	F688-Increase/Prevent Decrease in ROM/Mobility. AMBULATION-It is the policy of the facility to have ambulation be part of every resident's daily routine as allowed by their status. With collaboration of PT/OT, nursing will follow the recommendations to complete this. ROM-It is the policy of the facility to ensure the resident receives ROM in accordance with State and Federal Regulations. And those residents do not have a decline in ROM unless the resident's clinical condition demonstrates that the reduction in ROM is unavoidable, and a resident with limited ROM receives appropriate treatment and services to increase ROM and /or to prevent further	

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F 688	Continued From page 9 right pelvic fracture, morbid obesity, muscle weakness. R3's Therapy Recommendations for Nursing Staff, dated 9/28/21; specified orthotic soft resting right-hand splint to be applied at night and removed in morning by nursing staff. R3's Therapy Recommendations for Nursing Staff, dated 9/30/21, updated 10/5/21; indicated nursing staff were to complete assisted AROM and PROM [active/passive range of motion] exercises to bilateral upper extremities to sites including shoulder, elbow, wrist, fingers. Nursing staff were to complete 10 repetitions to each site once daily. Therapy recommendations also indicated nursing staff were to complete PROM to BLE's to sites including ankle, knee, hips. Nursing staff were to complete 8-10 repetitions to each side once daily. Occupational therapy (OT) and physical therapy (PT) treatment encounter notes were requested and not received. On 6/27/22, at 6:34 p.m., R3 was observed sitting in her wheelchair in room. R3's bilateral fingers were visualized to appear tight, rigid, and curled inwards toward palm of hands. When R3 tried to extend her fingers of bilateral hand, fingers observed to straighten slightly, remaining mostly curled inwards to palm of hands. R3 was able to make a fist with left hand, although weak; unable to make a fist with right hand. R3 indicated she had worked in past with PT and OT, although had been several months ago. R3 stated she had not received bilateral upper/lower extremitiy (BUE or BLE) exercise therapy by staff, exercise therapy for BUE was completed independently occasionally, consisted of squeezing foam ball with bilateral fingers of hand. R3 indicated feeling	F 688	decrease in ROM or contracture formation. In regards to resident #3 & 12 physician was consulted and orders for PT/OT to eval and treat were obtained. Staff was educated on ROM/splint and mobilizing residents per PT/OT recommendations. Residents currently not receiving PT/OY services will be reviewed at weekly at Medicare Meeting. PT/OT will complete screens on residents with quarterly assessments and treat as needed. Policy & procedures updated or initiated. Effective 8/05/22 All staff will be re-educated on ROM and Ambulation for all residents, in collaboration with PT/OT. PT/OT will review proper ROM, ambulation and transfers with staff. Staff will document any refusals on spreadsheet found in Therapy orders book, and on POC, CNA to alert charge nurse of any refusals. Walking program initiated and to be documented in Therapy orders book, this will be updated by DON/designee. Care plans updated following PT/OT recommendations. Audits will be completed weekly x 4 and monthly x3 and ongoing as needed. The results of these audits will be reported to the QAPI committee for further review and recommendations.	

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F 688	Continued From page 10 contractures to right hand had worsened since last assessment by OT and PT. During an interview, on 6/30/22 at 10:04 a.m., nursing assistant (NA)-D indicated typically working night shift, was aware of R3's contractures to bilateral hands. NA-D stated R3's bilateral fingers of hand were stiffening, had weakness to bilateral hand, right hand worse than left hand. NA-D stated R3 was not receiving any restorative nursing therapy, was not aware of any exercise regimen to complete to BUE's or BLE's. NA-D indicated R3 had foam balls to use for strengthening of bilateral hand, completed strengthening exercises independently. NA-D stated was unaware of any brace or splint needing to be applied at night-time for contracture to R3's right hand. When interviewed, on 6/30/22 at 10:26 a.m., OT indicated was filling in for day, not regular staff, was not familiar with R3 or therapy needs. OT attempted to look for R3's therapy file, unable to locate. OT stated would check with PT to further assist in finding R3's therapy file. During an interview, on 6/30/22 at 11:00 a.m., licensed practical nurse (LPN)-A indicated awareness of R3's bilateral hand contracture, right side worse than left side. LPN-A stated R3 worked with PT and OT several months ago, had reached plateau and no longer needed services. LPN-A indicated since PT and OT discharge, R3 should have been receiving restorative nursing services. LPN-A stated when receiving orders from PT and OT for continued resident therapy; PT and OT staff communicate and provide resident orders directly to nursing staff, nursing staff then places resident therapy orders for all	F 688		

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F 688	Continued From page 11 staff to review into a white binder labeled, "Therapy sheets for Residents." LPN-A indicated nursing staff provides a copy of the resident's therapy order to the director of nursing (DON), DON then places the resident's therapy order into their care plan and NA assignments through the electronic medical record (EMR) system, which then triggers tasks for NAs to complete on their assignment sheet during their shift. LPN-A stated resident therapy orders are communicated to all staff during change of shift report as well. LPN-A indicated awareness of R3's exercise regimen, stated NAs were to perform range of motion (ROM) to BUE's; R3, independently, should be completing strengthening to bilateral hand by squeezing foam ball in hands. When interviewed, on 6/30/22 at 11:24 a.m., PT indicated R3 was evaluated and offered services, but never wanted to participate, just wanted to be left alone in bed in room. PT stated R3 had orders for continued AROM and PROM exercises to BUE's and BLE's, should be continued restoratively to prevent deconditioning to BUE's and BLE's. PT indicated since R3 would refuse to participate in therapy services, R3 reached plateau, discharge orders consisted of re-evaluation if deconditioning occurs or on an as needed (PRN) basis. During an interview, on 6/30/22 at 12:51 p.m., the director of nurses (DON) indicated unawareness of R3's therapy orders consisting of; soft splint to be applied at night and removed in morning, exercise regimen for AROM and PROM to be completed to BUE's and BLE's. The DON stated resident therapy orders are entered into their care plan and NA "Kardex," assignments, through the EMR system by her or other nursing staff. The	F 688		

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F 688	Continued From page 12 DON indicated when resident therapy orders are entered on NA "Kardex," NAs can view tasks needing to be completed for resident during shift. The DON reviewed R3's care plan and NA assignments, confirming R3's care plan does contain AROM and PROM exercises to be completed to BUE and BLE daily, as well as soft resting right-hand splint to be applied at night and removed in morning. The DON indicated upon further review, R3's therapy order for soft resting right-hand splint application and exercise therapy to be completed to BUE's and BLE's was entered into EMR system incorrectly. The DON stated R3 should have received soft resting right-hand splint application and exercise therapy to BUE's and BLE's, and confirmed those services were not provided as ordered per therapy recommendations. On 6/30/22 at 3:59 p.m., PT re-evaluated R3's bilateral hand contractures and indicated continued stability with no new or worsening changes in condition. R12 When interviewed on 6/28/22, at 11:11 a.m. R12 stated he was frustrated as he had not been feeling well. R12 said he felt like he was "going backwards." R12 stated he was unsure what the facility was doing to help him with his health conditions. He expressed frustration that he was not receiving therapy, and he was unsure why that was. Druing a follow up interview on 6/29/22, at 11:42 a.m. R12 was unable to state how frequently staff offered to walk him, but said sometimes he is in pain, or is not feeling strong enough, but he could	F 688		

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F 688	Continued From page 13 not relate a frequency. R12 stated he was willing to go for a walk on 6/29/22, but it had not been offered. According to R12's 5 day admission MDS dated 5/14/22 (a readmission after hospitalization), R12 was cognitively intact, had disgnosis including cancer, diabetes, heart failure, bipolar mental illness, renal issues and neuropathy among other co-morbidities. According to a written physical therapy recommendation dated 5/18/22, R12 was to be walked at least 50 feet, 1-2 times per day with a four wheeled walker. According to R12's care plan, R12 has a focused problem area for activities of daily living dated 3/31/21 with an updated intervention added 3/15/22 that indicated R12 had a walking program and he was to be walked with a four wheeled walker 2-3 times daily by nursing for a distance of 50 feet with stand by assist. According to R12's electronic health record in the section titled "tasks" over the past 21 days, R12 was marked one time as being independent in ambulation, and the remainder of all entries, one per shift, documented "the activity (ambulation) did not occur." When interviewed on 6/29/22, at 11:50 a.m. a licensed practical nurse (LPN)-A stated R12 was able to walk with a cane, but LPN-A did not know a frequency. LPN-A stated a belief that R12 didn't want to walk. When interviewed on 6/29/22, at 11:53 a.m. a nursing assistant (NA)-A stated R12 "liked to	F 688		

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F 688	Continued From page 14 walk" but was unable to state a frequency with which R12 should be walked saying, "we try to walk anyone who can walk. If we offer, and they refuse we chart that." When interviewed on 6/29/22, at 11:58 a.m. NA-B stated the only way she knew of who to walk in the facility was because she "had learned it." NA-B stated R12, "is not walking, he is in wheel chair. He just need some help. He can use wheel chair and can transfer himself." When interviewed on 6/30/22, at 10:03 a.m. an occupational therapist (OT) stated R12 had been receiving therapy, but had been discharged. OT stated therapy would write recommendations for the nursing staff to follow after discharge to maintain abilities. OT stated she believed the information was posted in a communication book for nursing assistants. When interviewed on 6/30/22, 11:14 a.m. a physical therapy aide (PTA) stated R12 had been receiving therapy to work on strengthening and ambulation. PTA stated recommendations had been provided to the nursing department to carry on the work after discharge from therapy services. PTA stated an expectation for nursing staff to follow the recommendations, or at least offer ambulation or exercise to the resident. PTA stated R12 may suffer a decline because he does not always like to do the exercise, but stated the nursing staff should offer regardless. PTA also stated any complaints from R12 about getting weaker should be reported to therapy so that he could be screened again to see if he might need therapy to be reinstated. PTA expressed concern that if R12 did not walk twice daily as recommended he would lose strength and would	F 688		

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F 688	Continued From page 15 not be safe when he would next try to walk. PTA said the facility had a weekly meeting to go over caseloads and concerns, but could not recall anyone saying R12 was refusing to walk or that his condition had changed. When interviewed on 6/29/22, 12:16 p.m. director of nursing (DON) stated nursing staff should be able to access information about a resident's mobility on their electronic health record. DON stated an expectation for staff to follow therapy recommendations and if R12's chart said he was to be walked 1-2 times per day, they were to offer to walk him 1-2 times per day. DON said if documentation on the health record task list indicated "activity did not occur" it meant the staff had not walked the resident or had not completed the designated task. DON stated if a resident indicated they thought they were getting weaker, this should be reported to the charge nurse who should then try to figure out what was going on, including the involvement of the therapy department. DON also stated a resident's care plan should be updated as to why a resident is not walking or how they should be walked if that had changed. Facility policy and procedure titled, "Range of Motion Screening, Voluntary Movement ROM Assessment," revised 10/17 and reviewed 3/14/19, consisted of; program description and rationale: to promote each resident's ability to maintain or regain the highest degree of independence as safely as possible, to promote wellness and debilitation, includes, but is not limited to programs in range of motion, splint or brace assistance. Policy: each resident will be screened for restorative nursing upon admission, annually, and with any significant change in	F 688		

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F 688	Continued From page 16 function, appropriateness for a restorative program will be determined by the interdisciplinary team as needed and/or may be determined as a continuation of care following a course of physical, occupational, or speech therapy, licensed personnel supervise the restorative nursing programs, documentation of the interventions and the resident's response will be completed with each implementation, each resident's progress will be evaluated quarterly and with any change of condition, monthly nursing documentation should address resident functional status in relation to the plan of care. A facility policy for contractures was requested, but was not received. A facility policy last revised August of 2017 and titled Ambulation and Transfers policy, indicated "Ambulation will be a part of every resident ' s daily routine as allowed by their status." Furthermore, the policy indicated nursing was to follow restorative programs that had been developed for residents.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 689	F689-Free of Accident	8/5/22

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F 689	Continued From page 17 review, the facility failed to follow intervention in place to prevent potential for injury for 1 of 1 resident's (R8) when the care plan was not followed when transferring a resident off the floor. In addition,, the facility failed to identify a potential hazard for 1 of 1 resident (R10) who was observed with a hot glue gun. Findings include: R8 According to R8's quarterly Minimum Data Set (MDS) assessment dated 5/7/22, R8 had severe cognitive impairment. R8 had a diagnosis of non-traumatic brain dysfunction and Alzheimer's disease, history of stroke and osteoporosis (brittle/porous bones related to aging). The MDS indicated R8 required the extensive assistance of two persons to transfer, did not have steady balance and walking did not occur. Furthermore, the MDS indicated R8 had limited range of motion of both lower extremities. R8's care plan had a focused problem area dated 7/13/20 that indicated a problem with self-care and an intervention last updated 11/26/20 was listed as, "TRANSFER: The resident requires assistance with transfer with 2 of care team members for assistance with transfers. May need to use EZ stand (mechanical lift) prn (as needed), Provide direction by using short, simple instructions. Provide resident with step-by-step guidance during transfer process, encouraging their participation as much as possible." On 6/27/22, at 4:32 p.m. R8 was observed crawling on the fall, coming out of the door to her room. R8 stated, "I'm okay, I just want to talk to (my neighbor)." R8's bed was noted to be lowered	F 689	Hazards/Supervision/Device It is the policy of the facility that staff use gait/transfer belts on all residents during standing or mobility activities unless contraindicated. The use of gait/transfer belts is to maximize resident and staff safety during all standing and mobility activities with collaboration of PT/OT. In regards to residents #8 staff was reeducated on proper use of gait belt during transfers. Therapy will reassess transfers of resident #8 with staff to ensure proper technique with use of gait belt. Res #12 Hot glue gun was removed from resident□s room after education to resident; he will request glue gun and have staff supervision with use to avoid risk of injury from a burn or fire hazard. All other residents will be evaluated quarterly by therapy screens and mobility assessments. If staff notice changes/declines they are to report to charge nurse/DON for assessment. Current policy/procedure updated. Care plans updated following PT/OT recommendations. Effective 8/05/22 all staff will be educated on safe gait/transfer belt use. PT/OT will instruct all staff on proper use of gait/transfer belt. Use of gait/transfer belt needed will be updated and placed in therapy orders book by DON or designee.	

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F 689	Continued From page 18 all the way to the floor, and a thick cushion was placed next to the bed. A tab alarm system was in place, but the alarm had been somewhat disassembled. When staff came to attend to R8, the director of nursing (DON) and a nursing assistant applied a gait belt, but had difficulty getting R8 to her feet and into a wheelchair. The DON said, "(R8) is known to do this, she will turn off her fall alarm and get out of bed, that is why her bed in down to the floor with a fall mat next to it." R8 was not put back to bed at that time. On 6/29/22, 11:58 a.m. R8 had been sitting in a recliner in the living area of the facility watching television. Two nursing assistants, (NAs)-A&B approached R8 and informed her that it was time for lunch. The NAs placed a gait belt loosely around R8's waist. It drooped down near her buttocks as she was scooted to the edge of the chair. R8's wheelchair had been placed about three feet away. NA-A and NA-B leaned over R8, and each of them hooked an arms under her armpit area, grabbed the gait belt and prompted her to stand while they pulled under her arms and on the belt. The gait belt slid up R8s back and up into her armpit region as well. R8 did not bear any weight on her legs, but buckled at the knees and sagged, hanging by the belt and arms. R8's arms went up at the shoulder and her legs were bent under her. NA-A tried to reach the wheelchair, but could not quite reach it, and instructed NA-B to "grab it." NA-B let go of the gait belt and grabbed at the chair and was able to drag it closer. R8 continued to sag and hang from their hooked arms and the gait belt under her arms, and NA-A and NA-B dragged her the last few feet to the wheelchair and turned to set her on the seat. NA-A then took R8 to the dining area. When interviewed immediately following the transfer,	F 689	Audits will be completed weekly x 4 and monthly x3 and ongoing as needed. The results of these audits will be reported to the QUAPI committee for further review and recommendations.	

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F 689	Continued From page 19 NA-B stated the only way she knew of how to transfer a resident was because she "had learned it." NA-B stated the transfer had been done correctly because two persons and a gait belt had been used. NA-B did not think a mechanical lift had ever been used for R8. When interviewed on 6/29/22, 12:16 p.m. the DON stated the facility completed assessments to determine the best way to safely transfer any of the residents. DON stated, in general, a two person assist should be accomplished by, "snuggly applying a gait belt, allowing only two finger widths of space between the belt at the resident's waist. The staff should then assist the resident to stand by grasping the gait belt in the back and pull on the belt and prompting the resident to stand." If the resident started to sag or the belt slip, DON stated they should be allowed to sit back down, and then the gait belt should be reapplied. DON also stated that if the resident was unable to safely support their weight with a two person assist and gait belt, the staff should get an EZ stand. DON stated underarm hooking and lifting a resident was not appropriate and stated the following concerns, "dislocation could occur, the muscles could get over stretched; we don't chicken wing them." The DON stated all residents had a care sheet describing what type of cares to give and all nursing staff could access the information. When interviewed on 6/30/22, 11:14 a.m. a physical therapy aide (PTA) stated concerns when a gait belt is not sufficiently snug, and lifting under the arms was not safe transfer technique. PTA also stated, if a resident is slipping or sagging it would be easy for the resident or the staff to get their feet tangled and for a fall or injury	F 689		

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F 689	Continued From page 20 to occur. PTA stated a person who does not bear weight when approached for a transfer could be left, and reapproached a bit later, or staff could offer the use of the EZ Stand. A policy titled Ambulation and Transfers and last updated August, 2017 indicated the procedure for transfers was to consult the care plan; to apply the gait belt around the resident's waist snugly to eliminate the possibility of sliding up on the ribs and to bring the resident to a standing position by grasping the belt with both hands while remaining upright, and creating a broad base of support by spreading feet. Finally, the procedure indicated to return the resident to a comfortable position in the wheelchair; however, did not provide information on how best to perform this. The procedure did not indicate what to do if the resident was unable to follow instructions. R12 According to R12's 5 day admission MDS dated 5/14/22 (a readmission after hospitalization), R12 was cognitively intact, newly diagnosed cancer, diabetes, heart failure, renal issues and neuropathy. The MDS also indicated the use of oxygen. According to R12's care plan, R12 has a focused problem area for acute/chronic pain related to diabetic neuropathy, last updated 5/11/22; however, the care plan did not address safety issues that might arise in relation to his neuropathy. Hazards related to oxygen use were not included in R12's care plan. When interviewed on 6/28/22, 11:11 a.m. R12 stated he was frustrated as he had not been	F 689		

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F 689	Continued From page 21 feeling well. R12 said he felt like he was "going backwards." R12 stated he was unsure what the facility was doing to help him with his health conditions. R12 was observed to rub his left arm, and stated he had problems with pain and sensation in that limb. R12's room was observed to have a large table with craft items scattered about including paints, stickers, papers (flammable items), and a hot glue gun that was laying on its side on the vinyl table cloth, but was not plugged in. R12 was observed to utilize oxygen via nasal cannula at all times. During an observation and interview on 6/30/22, 8:51 a.m. R12 was observed seated at his craft table working on a project decorating garden trolls. His oxygen was in place and infusing. At that time, R12 expressed frustration that he was not able to use his hands as well as he used to due to his neuropathy. R12 stated he was not as adept at handling things, and in fact, had dropped one of the gnomes the other day. The hot glue gun was within a few inches of where he was working, and laying on the flammable vinyl table cloth and near combustible items, but was not plugged in. R12 was unsure of when he had last used the hot glue gun. When interviewed on 6/30/22, 10:03 a.m. an occupational therapist (OT) stated R12 had received therapy services, and they had worked on strengthening, endurance and pain control. OT stated R12 was somewhat limited in his ability to use his left arm because of pain. OT was aware that R12 enjoyed doing craftwork, but was not aware he has been using a hot glue gun. OT expressed concern that R12 might drop the glue gun, or should he touch it and/or hot glue would land on his skin, with neuropathy he might not be	F 689		

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F 689	Continued From page 22 able to feel the heat and respond appropriately. When interviewed on 6/30/22, 12:01 p.m. DON stated she was aware that R12 had a hot glue gun in his room, but was not sure when it was last used. DON stated R12 has been known to use the hot glue gun, and he had decorated his cell phone with glued on gems. DON expressed concern that the hot glue gun was a potential source of heat that might be a fire hazard and when using oxygen, R12 would be at a higher risk for injury should a fire occur. DON also stated R12 had recently had increased problems with holding things, and had in fact, dropped his phone and broken it due to his neuropathy. DON stated the facility did not have a policy for the use of hot glue guns, but planned to develop one.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		8/5/22

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F 690	Continued From page 23 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate catheter care was provided to prevent potential for urinary tract infection (UTI) for 1 of 1 resident (R3) reviewed for catheter cares. Findings include: R3's quarterly Minimum Data Set (MDS) assessment, dated 3/19/22; indicated R3 had moderately impaired cognition and functional limitations in activities of daily living (ADL). R3's MDS identified bilateral hand contractures, required extensive assistance of 2 staff with toileting and personal hygiene. The MDS further indicated diagnosis included pressure ulcers to buttocks, rhabdomyolysis (breakdown of muscle), and muscle weakness, requiring indwelling foley catheter. R3's face sheet, indicated diagnosis of pressure	F 690	F690-Bowel/Bladder Incontinence, Catheter, UTI Catheter/peri care is the policy of this facility that pericare will be performed on all incontinent residents q shift and prn incontinence, and that catheter care is routinely performed twice daily and prn. In regards to resident #3 staff was reeducated on proper pericares/catheter cares for resident with catheter. No other residents have urinary catheters. All residents with new urinary catheter placement staff will demonstrate competency to prevent infection/decline. Current policy/procedure updated. Audits will be completed weekly x 4 and	

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F 690	Continued From page 24 ulcer of right lower back-stage 4, colostomy, pressure ulcer of right hip-stage 3, morbid obesity, and physical debility. R3's care plan, identified placement of indwelling catheter due to pressure ulcer to buttock area, also indicated to perform catheter care twice daily. R3's provider note, dated 6/15/22, indicated chronic indwelling catheter due to decubitus ulcers of buttocks and lower back. Provider's note did not mention any recent urinary infection. During an observation, on 6/29/22 at 10:18 a.m., while NA-A was visualized performing peri and catheter cares to R3, NA-A was observed to wear gloves while washing left upper inner thigh with plain water and clean washcloth. NA-A folded washcloth over to new portion of rag x4, washing only left upper inner thigh region, then dried with a clean towel. NA-A grabbed a new clean washcloth and began to cleanse right upper inner thigh. NA-A folded washcloth over to new portion of rag x4, washing only right upper inner thigh region, then dried with a clean towel. NA-A indicated during procedure, R3 does not like to be cleansed with soap while in bed, only will use soap when taken to shower or bath. When NA-A was asked why cleansing of labia, urethral meatus, and catheter had not been completed, only cleansing of bilateral upper inner thighs during cares; NA-A responded that she had cleansed sites. NA-A was observed to remove her gloves and changed into a new pair of clean gloves to perform urinary catheter drainage bag cares. With drainage bag attached to side of bed, NA-A cleansed end tip of drainage bag tubing with an alcohol wipe, released clamp for	F 690	monthly x3 and ongoing as needed. The results of these audits will be reported to the QUAPI committee for further review and recommendations. Effective 8/05/2022 all staff will be educated and assessed for competency on peri/catheter care.	

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F 690	Continued From page 25 urine to drain into center of a graduated cylinder that another NA was holding for NA-A. R3's urine observed at time to appear amber in color with lots of sediment. NA-A was then visualized to re-clamp end tip of drainage bag, cleansed end tip of drainage bag with a new alcohol wipe, placed end tip into plastic holder of drainage bag. When interviewed, on 6/30/22 at 12:59 p.m., the director of nursing (DON) indicated all NAs had to complete a competency checklist upon hire, which included peri and catheter cares. The DON stated before an NA can perform resident cares independently, they had to have skills checked off by a veteran NA and DON to ensure competency. The DON indicated NAs were rechecked on their care competency skills in 3-6 months post hire to determine if any additional education was needed. The DON stated unawareness of concerns with NAs providing inappropriate peri and catheter cares, indicated all NAs working independently had been deemed competent in providing peri and catheter cares. The DON was informed while NA-A was observed per surveyor performing peri and catheter cares, NA-A was visualized to cleanse bilateral upper inner thigh, had not cleansed peri area or indwelling foley catheter. The DON stated NA-A was a newer employer, had only worked at facility for a few months. The DON confirmed cleansing of resident's bilateral upper inner thigh was not appropriate peri and catheter care. The DON indicated it was her expectation for all nursing staff to cleanse peri and catheter sites per standards of care taught, if questions or concerns about procedure, should seek further clarification from competent nursing staff or DON. A facility policy for peri care and catheter care	F 690		

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F 690	Continued From page 26 were requested but was not received.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		8/5/22

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F 758	Continued From page 27 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to evaluate sleep, mood and behavior to justify the use of a psychoactive medication and did not provide a routine for monitoring the effectiveness of new psychotropic medications or provide non-pharmacological interventions for 1 of 4 residents (R10) reviewed for unnecessary medication. Findings include: During an interview on 6/27/22, at 2:52 p.m. R10 stated "my mood affects my sleep, and I pick at my skin when I'm sleep". R10 had an old scar from his kidney transplant with areas of irritation where he had picked at it. R10 did not complain of his current mood and said he had plenty to keep him busy as he had all his electronic gadgets and had worked with computers for a living his entire life. His affect was pleasant, and animated. According to R10's Minimum Data Set (MDS) quarterly assessment dated 5/17/22, R10 was cognitively intact but suffering from multiple	F 758	F758-Free from Unnecessary Psychotropic meds/PRN use It is the policy of the facility to complete a comprehensive sleep assessment to determine the need for sleep aids ordered for resident with insomnia for unnecessary medications. A sleep study was conducted and evaluated on Res#10 for possible changes, care plan for sleep initiated. Pharmacist (Omnicare) suggested that DON contact Mayo psychiatrist to rewrite reason for Zyprexa other than sleep. DON has faxed request to Mayo psychiatrist for appropriate diagnosis. All other residents that are currently on psychotropics or other sleep aides were reassessed for changes and care plans initiated or revised. Physician was updated of these findings. Facility policy/procedure-Psychotropic	

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F 758	Continued From page 28 significant physical and emotional disabilities. The MDS did not indicate any episodes of delirium, hallucination, delusions or other behavioral manifestations including depression. R10's diagnosis list indicated R1's primary diagnoses for admission was type 2 diabetes mellitus . The list indicated R10 had multiple mental health diagnosis including anxiety, depression, post-traumatic stress disorder and a diagnosis for Asperger's syndrome. The list also indicated R10 suffered from insomnia. The list did not specify any associated problems of psychosis such as delusions or hallucinations. According to R10's sleep evaluation dated 5/17/22, R10 had indicated a satisfaction with his sleep, getting up only 1-2 times per night to urinate. The assessment indicated he did not feel fatigued during the day. No other information related to sleep was included in the sleep evaluation. A prior sleep evaluation dated 11/14/21 included the same information for R10 related to his sleep; however, it also indicated he had been taking 8 mg of Melatonin for sleep at that time. According to R10's physician orders R10 had orders for the following psychotropic medications: Effexor XL (an antidepressant) 37.5mg for depression (discontinued 6/7/22), Sertraline (an antidepressant) 200mg daily, Trazodone (an antidepressant) 50mg at bedtime for sleep, Olanzapine (an antipsychotic) 2.5 mg for sleep/depression, started 6/8/22. In addition, R10 had an order for Melatonin (hormone for sleep regulation) 6mg for sleep, (increased to 9mg for sleep on 6/27/22)	F 758	Drug Assessment updated. Effective 8/05/2022 all staff will be educated on Sleep enhancement and alternative therapies for sleep to prevent unnecessary medications. Audits will be completed weekly x 4 and monthly x3 and ongoing as needed. The results of these audits will be reported to the QAPI committee for further review and recommendations.	

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F 758	Continued From page 29 A review of R10's care plan indicated a focus problem area dated 7/9/21 for impaired coping. An associated intervention to "evaluate sleep pattern" was added on 7/9/21 without any further explanation. An additional focus problem area dated 9/2/21 indicated R10 was "at risk for depression." This problem area included two interventions, one to assist with making appointments and to talk with R10 about his electronic devices because he enjoys that. No focus problem area was found addressing the use of an antipsychotic. Outside of the listed coping and depression, no other target behaviors were listed. Identification of any behavioral symptoms requiring the use of an antipsychotic were not uncovered in R10's facility medical record, and on-going monitoring of the effectiveness of an antipsychotic for sleep was not found in R10's facility medical record. Documentation of non-pharmacological interventions for sleep or other behavioral manifestations were not found in R10's record. When interviewed on 6/30/22, at 3:49 p.m. director of nursing (DON) stated R10 had a psychological history and had been to the psychiatrist. DON described R10 as having a diagnosis of anxiety and depression, and also of PTSD and Asperger's, describing behaviors of problems with social relationships at times. DON described occasions of unrealistic ideation such as becoming fixated on problems with the facility heating system, the internet or his medical care. DON described R10 as "streaming everything all at once" in his room with multiple electronic devices streaming television shows, videos,	F 758		

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F 758	Continued From page 30 music etc. DON stated R10 had disliked the amount of internet available and had hacked in to the internet used for running their medical records, but had not accessed the records. The DON stated R10 had told her his psychiatrist was going to put him on sertraline and olanzapine, and this had actually occurred when he last had a visit approximately a month prior to this interview. DON stated the psychiatrist had listed the olanzapine for sleep, but DON said this was not a medication usually given for sleep. DON had reached out to the psychiatrist, but stated the return call was made by a colleague. When the psychiatrist eventually called back, DON stated the reason given by the psychiatrist for choosing olanzapine was R10 had said he had used it in the past and it had been effective. DON was unable to locate documentation in the facility records indicating the medication had been effective in treating sleep or other psychiatric concerns since the medication was originally started on 6/8/22. DON stated non-pharmacological interventions should be used prior to the use or in conjunction with the use of psychotropic medication, but was unable to locate any documentation to indicate such interventions had been attempted for R10. A facility policy titled Psychotropic Drug Assessment last reviewed on September, 2013 did not apply to the use of psychotropics beyond indicating an assessment for abnormal involuntary movement assessments must be completed with the use of such medications.	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors.	F 759		8/5/22

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F 759	Continued From page 31 The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure that medication was administered according to standard of practice when using an insulin pen for 3 of 3 administrations observed for 2 of 6 residents (R1 and R10) receiving insulin at the facility. This resulted in a greater than 5% error rate at 11% for the facility. Findings include: During an observation on 6/29/22, 7:20 a.m. a licensed practical nurse (LPN)-A checked the medication administration record (MAR) for R10 to determine the insulin he was to receive. LPN-A removed an insulin administration pen (a container pre-filled with insulin that can be used to directly administer insulin without having to draw the medication into another syringe) that matched the MAR. The MAR and the label on the pen indicated the medication belonged to R10 and contained NPH insulin and R10 was to receive 18 units subcutaneously. LPN-A was observed to clean the tip of the pen with an alcohol swab and apply a disposable needle under a cap. LPN-A then turned the dial on the pen to match the ordered dose of 18 units without removing the cap over the needle. LPN-A then went directly to R10's room where she applied a pair of gloves and notified R10 that she was going to administer his insulin. The two of them identified an appropriate site, LPN-A cleansed the area with alcohol, removed the cap from the	F 759	F759-Free of medication Errors Rates 5 percent or More Proper Insulin Pen administration. It it's the policy of the facility that insulin is given by competent staff following the 7 rights of Safe Medication Administration. If the insulin is cloudy, gently roll the pen 10times and invert the pen 10 times. Place a safety needle on pen and twist the needle until tight-remove cap. Prime the pen-to do this dial 2 U and whilst holding the pen upwards (needle pointing upwards), push the dose knob until 0 is seen in the window-you should see insulin at the tip of the needle-if not seen repeat prime steps with another 2 U and if no insulin is seen at tip-change needle and repeat. Staff member involved reeducated on proper Insulin pen administration. All licensed nursing staff demonstrated proper technique and competency of use of insulin pens. Policy & Procedure updated. All current staff were educated on 7/25/22, new will staff will be educated upon hire. Audits will be completed weekly x 4 and	

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	245464	A. BUILDING _____ B. WING _____	C 06/30/2022

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F 759	Continued From page 32 insulin pen, pushed the needle into the fatty abdominal tissue, quickly injected the 18 units, held the pen in place for about 3 seconds and then removed it. LPN-A disposed of the needle and went to the MAR to document the insulin as having been given. During an observation on 6/29/22, 7:31 a.m. LPN-A checked the MAR for R1 and removed two insulin pens from the medication cart. LPN-A checked the labels against the MAR and determined that R1 was to receive 16 units of Lantus insulin and 12 units of Humalog insulin. LPN-A cleaned the tip of each pen, applied the needle and checking the MAR again, dialed the dose on the pen to match the ordered dose on the MAR. Using appropriate hand hygiene and gloves, LPN-A went to R1 in a private area, cleansed his skin on a site of his left abdomen. LPN-A removed the cap from the needle to the Lantus insulin, inserted the needle in the clean site, rapidly administered the insulin into the fatty tissue and after a few seconds removed the needle. LPN-A then cleaned a site on R1's right abdomen and repeated these steps with the Humalog. LPN-A then returned to the medication cart, disposed of the needles and returned both insulin pens to the cart, then documented the administrations as having been given. When interviewed on 6/29/22, 11:17 a.m. LPN-A stated the proper procedure for using an insulin pen was to alcohol the pen, attach a needle and then "express two units, then dial up the dose." LPN-A stated she did not recall having removed the cap from the needle and did not recall that she had "expressed two units" to prime the needle. LPN-A stated the needle should be primed prior to giving the dose so the resident	F 759	monthly x3 and ongoing as needed. The results of these audits will be reported to the QAPI committee for further review and recommendation.	

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F 759	Continued From page 33 receives the correct dosage. When interviewed 6/30/22, 12:22 p.m. the facility director of nursing (DON) stated the proper procedure for the use of an insulin pen what to do the initial label check against the MAR, clean the pen with alcohol and apply the needle. Following the application of the needle, DON stated the needle should be primed with 2 units of insulin and then the dose dialed. Following this, the nurse should go to the resident, explain the procedure, locate and clean the site and administer the insulin into fatty tissue, holding the pen in place for a few seconds so all of the insulin goes into the tissue. DON was not able to state an action to take if no insulin was seen coming from the needle when primed, "I don't know, as long as you use 2 units, you are pretty safe." The DON stated the needle must be primed to ensure the resident receives an accurate dose. DON stated not priming the needle could result in inaccurate dosing and blood sugar instability. A facility policy titled Use of Insulin Pens last revised June, 2022, indicated the proper procedure for the device was as follows: "Attach a safety pen needle to the pen device. A 2-4-unit prime is performed before every insulin injection to ensure a small amount of fluid flows through then end of the needle. If necessary, repeat until this occurs. Correct insulin dosage should be dialed and rechecked against resident ' s prescription prior to administration. Maintain a 10 second wait following delivery of insulin before removing the needle from the skin to ensure full dose delivery and leakage from the site."	F 759		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		8/5/22

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F 812	Continued From page 34 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired food were identified and removed, date opened containers of food stored in walk-in refrigerator and standup freezer, follow proper food handling practices to promote food safety. This had the potential to affect all 15 residents who were served food and beverages from the facility kitchen. Findings include: During interview and observation of kitchen on 6/27/22 at 2:35 p.m., with cook (C)-A, observed food items on shelves, in the walk-in refrigerator and standup freezer that were not dated or marked and/or were expired. C-A indicated all	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary It is the policy and procedure of OCR to store, prepare, distribute and serve food in accordance with professional standards for food service safety. All expired/not labeled food that was identified was immediately removed from the walk in refrigerator, standup freezer, and pantry and discarded from the facility. All areas were inspected for any items that were not labeled or expired and items were discarded. Any items that were unmarked/undated or expired were	

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F 812	Continued From page 35 kitchen staff were responsible for checking food for opened dates and expiration dates, all refrigerators and freezers should be gone through daily to check for expired or damaged food. C-A indicated if any food or drink is not dated when opened, it should be removed immediately. C-A stated all left-over prepared food should be discarded in 3-4 days and beverages when marked are good for 7 days from date opened. The following items were observed during tour: Shelves: 1. 1 bag of hot dog buns; opened and dated 6/25/22; exp date on bag 6/6/22 2. 3 bags of hot dog buns; unopened; exp date 6/6/22 3. 3 loaves of bread; unopened; dated on bag 6/13/22 Walk-in refrigerator: 1. 100% apple juice- 1.36L; approx. ¼ full; not marked/dated; exp date on container 1/20/23 2. 100% grape juice- 1.36L; approx. ¾ full; not marked/dated; exp date on container 2/15/23 3. 100% pineapple juice- 1.36 L; approx. ½ full; not marked/dated; exp date on container 11/19/22 4. sliced honey ham in facility zip lock bag; opened 6/17/22; use by date on by 6/27/22 5. Ensure clear- apple flavor- 8 oz. bottles (32 bottles remaining); unopened; expiration date on each bottle 4/1/22 6. Boost breeze- berry wild flavor- 8 oz. bottles (11 bottles remaining); unopened; expiration date on each bottle 11/1/21 7. Boost- chocolate rich- 8 oz. bottles (9 bottles remaining); unopened; expiration date on each bottle 3/30/22 8. Miracle whip light dressing- single packets;	F 812	removed immediately. All staff was reeducated on food storage/disposal so that items are immediately removed and discarded. All staff was reeducated on how to label and date items. The Dietary Manager initiated a list of items that are approaching expiration dates so that they can easily be discarded by that date. All staff was reeducated on proper food safety to prevent cross contamination and food borne illness. All staff was reeducated on proper use of PPE when serving, preparing, and storing of food. The Dietary Manager and Registered Dietician completed staff education 7/11/2022 in regards to storage, preparation, and dating of items to prevent cross contamination and food borne illness. Education included proper food safety and use of PPE when serving, preparing, and storing of food. The Dietary Manager will complete daily audits x 4 weeks then twice weekly to ensure undated/unlabeled/expired items are removed from storage areas before expiration dates. She will ensure all food items are dated and discarded per policy. The Dietary Manager will audit staff twice weekly x 4 weeks then monthly for proper food safety and use of PPE when serving, preparing, and storing of food. The results of these audits will be reported to the QAPI committee for further review and recommendation.	

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F 812	Continued From page 36 unopened; received in original box dated 11/30/20; no expiration date 9. cut-up radishes in facility zip lock back from facility garden; not marked/dated 10. celery- leaves on stalks observed to be dried and turning brown; original box date 6/6/22 11. La Victoria thick and chunky salsa 8.5 lb; ¼ left; opened date 4/20; unable to read expiration date on container 12. Broccoli in facility zip lock bag; observed to be brown in appearance; opened date on bag 5/11/22 13. Shredded lettuce; ¼ left; not marked/dated; observed to have increased moisture and brown in discoloration Stand-up freezer: 1. 1 bag of freezer burned hot dog buns; unopened; exp date on bag 4/29/22 When interviewed during brief kitchen tour, on 6/27/22 at 3:00 p.m., C-A indicated when food and beverage items are delivered to facility, staff rearranged food items in kitchen storage areas, moved newer food items to back and older food items to front to be used up first. C-A stated when food items were opened, staff would write an "open" date on top, to indicate to staff when needed to discard items. C-A indicated that she and staff try to go through food inventory and remove anything unmarked/undated or expired frequently, did admit to having some food items that should have been removed due to being unmarked/undated and expired. During observation and interview of dinner meal	F 812		

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F 812	Continued From page 37 on 6/29/22 at 12:18 p.m., dietary aide (DA)-A was visualized wearing hair net, walked over to employee sink, washed hands with soap/water, dried with paper towels, then applied clean gloves. DA-A walked over to counter in kitchen across from where steam table was set up, picked up resident meal tickets, placed on clean push-cart next to resident clean dishware. DA-A picked up resident meal ticket with gloved hands to read resident meal preference, set meal ticket on countertop across from steam table with gloved left hand, grabbed resident clean plate with gloved right hand, switched plate to glove left hand, picked up tongs with gloved right hand to place chicken drummy on plate, set plate back down on clean push-cart with left hand, grabbed a cutting knife with gloved right hand, while holding onto chicken drummy with left hand, would cut apart chicken drummy into pieces, set knife back down on clean push-cart with gloved right hand, picked apart chicken into smaller bite pieces with both gloved hands, picked plate back up with left hand, walked over to steam table, picked up spoon with gloved right hand and placed stuffing on plate, grabbed spoon for gravy with gloved right hand and poured gravy over stuffing, picked up spoon for green beans with gloved right hand and placed beans on plate, placed plate on resident tray and covered plate with covered top. DA-A was interviewed about process of food safety and cross-contamination with touching resident meal tickets, placing meal tickets on counter-top, touching meat when breaking it into smaller pieces. DA-A did not have a response other than she needed each resident meal ticket right in front of her to see what the resident's preferences and needs were, and still needed to be able to dish up, prepare meal accordingly.	F 812		

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F 812	Continued From page 38 During an observation and interview, on 6/29/22 at 12:26 p.m., C-A took R9's dinner meal and placed on tray. C-A grabbed a thermometer from her scrub top pocket and placed thermometer on R9's napkin, covering slightly over silverware (knife), next to meal, on tray. Once entering R9's room, C-A set meal tray down in front of R9, took cover off meal plate, picked thermometer up off his meal tray, alcohol wiped end of thermometer, then temped R9's pork chop with gravy. Once exited from R9's room, C-A was asked about food safety and process of cross-contamination with placing thermometer from her pocket onto R9's meal tray/silverware. C-A indicated she shouldn't have taken thermometer from her scrub top pocket and place on resident meal tray/silverware, confirmed potential risk for foodborne illness due to unhygienic practice. Facility policy for food storage, food safety, and prevention of cross-contamination and foodborne illness were requested. Facility policy and procedure manual: Director of Food and Nutrition Services Responsibilities, dated 2021, consisted of; the director of food and nutrition services will be familiar with all local, state, and federal regulatory requirements related to food, food safety and sanitation, and assure all requirements are met; employees will be trained, assisted, and encouraged as needed; food will be prepared in a manner that prevents foodborne illness; staff will follow proper sanitation and food handling practices. Facility policy, Food Safety for Vegetable	F 812		

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F 812	Continued From page 39 Gardens- Tips for Schools, Child Care and Long-Term Care Facilities, undated, indicated; poor personal hygiene is the cause of many foodborne outbreaks, surfaces used to prepare produce should be clean and sanitized. Facility policy, Long-Term Care Facility Garden Policy 2019, dated 11/28/17, consisted of; the facility should be following safe food handling practices once foods are harvested and brought to the kitchen for preparation, food safety requirements: the facility must procure food from sources approved or considered satisfactory by federal, state, or local authorities; nursing homes that have their own gardens such as, vegetable, fruit or herbs may be compliant with the food procurement requirements as long as the facility has and follows policies and procedures for maintaining and harvesting the gardens, including ensuring manufacturer's instructions are followed if any pesticides, fertilizer, or other topical or root-based plant preparations are applied.	F 812		

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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/28/2022. At the time of this survey, OSTRANDER CARE AND 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/29/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. OSTRANDER CARE AND REHAB is a 1-1/2 story building with partial basement. The building was constructed in 1968 and was determined to be of Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 25 beds and had a census of 13 at the time of the survey. There is a 2-hour fire-rated separation between the nursing home and assisted living facility. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 291 SS=C	Emergency Lighting CFR(s): NFPA 101 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 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test operability of emergency lighting devices in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1, 7.9.3, and 4.6.12.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 06/28/2022 between 10:30 AM to 01:30 PM, it was revealed that the emergency light testing documentation presented for review was missing an identifier as to which month the 90 minute testing was completed. 2. On 06/28/2022 between 10:30 AM to 01:30 PM, it was revealed that the emergency light testing documentation presented for review was	K 291	K291 Emergency Lighting It is the consistent practice of OCR to ensure all battery operated emergency lights operates properly with documentation acknowledging proper operation. 1. All battery operated emergency lights have had 90 min testing completed & documentation is signed off or initialed by staff that conducted testing and is clearly documented. 2. Maintenance staff will complete and document 90 min testing on an annual basis. The documentation binder has been clearly documented that the testing was completed and also noted that annual testing is due annually so that this does	7/7/22

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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) COMPLETION DATE
K 291	Continued From page 3 missing the sign-off or initials of the technician that conducted the testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	not occur again. 3. The Maintenance Director or designee monitors the documentation binder monthly to ensure that testing is maintained annually. 4. The Administrator or designee will review with the Maintenance Director and sign the maintenance log annually to ensure that the Battery Operated 90 min testing has been documented clearly by signing off or initialing in the month it was completed in. 5. Completion Date: 7/7/2022	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 353	K353	7/7/22

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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2022**

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K 353	Continued From page 4 and staff interview, the facility failed to inspect the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/28/2022 between 10:30 AM to 01:30 PM, it was revealed during the documentation review that no quarterly inspection reports were presented for review. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	Sprinkler System-Maintenance and Testing It is the consistent practice of OCR to ensure that the sprinkler system is maintained in accordance with NFPA 25. 1. The quarterly inspection of the wet pipe system was completed by Summit Fire Protection on 7/7/2022 with no problems. Documentation of inspection was placed in the maintenance documentation binder. 2. Maintenance staff will ensure that inspections occur quarterly. Summit Fire Protection has OCR scheduled for quarterly inspections to ensure that this does not occur again. 3. The Maintenance Director or designee monitors the documentation binder monthly to ensure testing is maintained quarterly. 4. The Administrator or designee will review with the Maintenance Director and sign the maintenance log quarterly to ensure compliance is maintained. 5. Completion Date: 7/7/2022	
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 355	K355	7/27/22

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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2022**

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K 355	Continued From page 5 facility failed to inspect the portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.4.1, 7.2.4.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/28/2022 between 10:30 AM to 01:30 PM, it was revealed during the walk-through of the facility that the fire extinguisher tags, intended for recording of monthly inspection, were not dated or initialed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	Portable Fire Extinguishers It is the consistent practice of OCR to ensure that portable fire extinguishers are installed, inspected, and maintained in accordance with NFPA 10. The facility did inspect and document portable fire extinguishers in the documentation binder but did not note on the extinguisher tag that it was inspected. 1. The monthly inspection tags on the fire extinguishers were dated and initialed after inspection. The documentation binder was updated to reflect that tags are to be signed off on the extinguisher. Summit completed the annual inspection and updated the fire extinguisher tags. 2. Maintenance staff will ensure that inspection of fire extinguishers are completed and signed off on a monthly basis on the tag located on the fire extinguisher. 3. The Maintenance Director or designee will continue to ensure inspection and documentation of the fire extinguisher inspection on the tag attached to the extinguisher on a monthly basis is completed per regulation. 4. The Administrator or designee will review with the Maintenance Director and sign the maintenance log quarterly to ensure compliance is maintained. 5. Completion Date: 7/27/2022	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills	K 712		7/7/22

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K 712	Continued From page 6 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/28/2022 between 10:30 AM to 01:30 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that a fire drill had been conducted for 3rd shift - 1st quarter 2022, and for 2nd shift - 4th quarter 2021 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	K712 Fire Drills It is the consistent practice of OCR to conduct and record fire drills in accordance with Life Safety Code NFPA 101. 1. The fire drill completed in the month of June 30 at 0600 am (shift ends at 0615) was completed for 3rd shift. Education was provided to Maintenance Department that a drill cannot occur prior to the actual shift start time. 2. Maintenance staff will ensure that fire drills are completed at expected and unexpected times under varying conditions, at least quarterly on each shift after the shift begins or before it ends. The fire drill schedule was also updated to include the shift start and end times. 3. The Maintenance Director and/or designee will complete the required fire drill procedure monthly and place in the documentation binder to ensure fire drills are completed according to regulation. 4. The Administrator or designee will	

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K 712	Continued From page 7	K 712	review with the Maintenance Director and sign the maintenance logs to ensure completion of the fire drill according to regulations. 5. Completion Date: 7/7/2022	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power	K 918		8/5/22

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K 918	Continued From page 8 source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition) 8.3.4, 8.4.9, 8.4.9.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/28/2022 between 09:00 AM to 01:00 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that the required, once every 36 months - 4 hour continuous run of the emergency generator is being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	K918 Electrical Systems It is the consistent practice of OCR to test the onsite emergency generator per NFPA 99 and to conduct a 4 hours continuous run of the emergency generator. 1. The 4 hour onsite emergency generator check will be completed by Interstate Power on 8/9/2022. Documentation of the inspection will be placed in the maintenance documentation binder. 2. Maintenance staff will ensure a continuous run time of 4 hours occurs every 36 months for the onsite emergency generator. 3. The Maintenance Director or designee will monitor the documentation binder to ensure testing is completed per regulations. Maintenance Director will schedule 4. The Administrator or designee will review with the Maintenance Director to verify that this has been completed and documented. 5. Completion Date: Scheduled 8/9/2022 with Interstate Power Generator Inspector	