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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H15B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00922

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245464**

2.STATE VENDOR OR MEDICAID NO.
(L2) **363670400**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/04/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sue Miller, HFE NEII 03/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/12/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/20/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On March 4, 2013, a Post Certification Revisit (PCR) was completed by the Department of Health and on February 17, 2013, the Minnesota Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility had not achieved substantial compliance pursuant to the January 17, 2013 extended survey, effective February 26, 2013. Refer to the CMS 2567b for both health and life safety code.

Effective February 26, 2013, the facility is certified for 25 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5464

April 12, 2013

Mr. Lloyd Swalve, Administrator
Ostrander Care And Rehabilitiation
305 Minnesota Street
Ostrander, Minnesota 55961

Dear Mr. Swalve:

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 February 26, 2013 the above facility is certified for:

25 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4118 Fax #: (651) 215--9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 12, 2013

Mr. Lloyd Swalve, Administrator
Ostrander Care And Rehabilitation
305 Minnesota Street
Ostrander, Minnesota 55961

RE: Project Number S5464024

Dear Mr. Swalve:

On February 5, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on January 17, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On March 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 17, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 17, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 26, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 17, 2013, effective February 26, 2013.

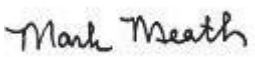
However, as we notified you in our letter of February 5, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 17, 2013.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5464r13.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245464	A. Building B. Wing	3/4/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **02/01/2013**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **02/01/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **02/26/2013**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/01/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **01/31/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/11/2013**
ID Prefix **F0354** Reg. # **483.30(b)** LSC	Correction Completed **02/26/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/01/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **02/11/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/01/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/MK	03/12/2013	08769	03/04/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/17/2013			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245464	A. Building B. Wing 01 - MAIN BUILDING 01	2/17/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0054	02/13/2013	ID Prefix Reg. # NFPA 101 LSC K0069	02/13/2013	ID Prefix Reg. # NFPA 101 LSC K0144	02/13/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	03/12/2013	25822	02/17/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/16/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H15B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00922

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245464**

2.STATE VENDOR OR MEDICAID NO.
(L2) **363670400**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/17/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

At the time of the January 17, 2013 extended survey the facility was not in substantial compliance with Federal participation requirements. Conditions in the facility has been determined to constitute substandard quality of care. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Michelle McFarland, HFE NEII — 02/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 03/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS
Posted 03/20/2013 CO. H15B

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9226

February 5, 2013

Mr. Lloyd Swalve, Administrator
Ostrander Care And Rehabilitation
305 Minnesota Street
Ostrander, Minnesota 55961

RE: Project Number S5464024

Dear Mr. Swalve:

On January 17, 2013, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Licensing and Certification
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesoga 55904

Telephone: (651) 201-4118

Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 26, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 26, 2013 the following remedy will be imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Ostrander Care And Rehab is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective April 17, 2012. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division

Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

imposition of these remedies.

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

If substantial compliance with the regulations is not verified by April 17, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 17, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

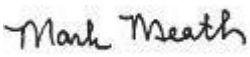
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245464	A. BUILDING _____ B. WING _____	01/17/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard recertification survey was conducted and an extended survey was also completed at the time of the standard survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for	F 156 2-20-2013 MN	F156 The DON, who issues all Medicare Denials, has reviewed the guidelines for timely issuance of the ABN and SNF MC Denial letters. The DON will issue both forms at least 48 hours prior to the last day of MC coverage. The DON will make copies of the notices and maintain a file and tracking tool for the notices. The BOM will be given copies of the forms and will monitor the process.	2/1/13 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lloyd Swalve — TITLE: Administrator — (X6) DATE: 2-14-13

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

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F 156	Continued From page 2 advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to provide the appropriate liability	F 156		

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F 156	Continued From page 3 and appeals notice for 1 of 3 residents (R20) reviewed for liability notices and beneficiary appeals rights review. Findings Include: R20 documentation had been reviewed and it revealed that the last covered day of Medicare services was 8-10-12. R20 remained in the facility after completion of Medicare coverage and only received the Notice of Provider non-coverage form CMS 10123, also known as the "generic notice." However, R20 had not received the denial notice form Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) for demand bill. During an interview on 1-15-13 at 3:49 p.m. the director of nurses (DON) verified the SNFABN denial form was not completed upon resident's discharge from Medicare covered services. The DON stated she was on vacation and the correct Medicare denial forms were not issued in her absence. During an interview on 1-17-13 at 1:58 p.m. the business office manager verified resident used 96 days of Medicare coverage during his current nursing home stay.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176		

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F 176	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R19) was assessed to safely self-administer nebulizer treatment. Findings include: R19's diagnoses included but not limited to asthma and chronic obstructive airway disease. R19's quarterly Minimum Data Set dated 12/17/12 indicated moderate cognitive impairment, had shortness of breath at rest, upon exertion and when lying flat. During the review of the signed physician orders dated 11/28/12, they included DuoNeb (medication used to clear the bronchi) 0.5 milligrams (mg)-3 mg in 3 milliliter solution four times a day (QID) for obstructive airway disease. During observation on 1/15/13, at 11:05 a.m., R19 was sitting in wheelchair in room with nebulizer mask over nose and mouth with nebulizer solution being dispensed. No licensed staff present in room or in hallway. During interview on 1/15/13, at 11:08 a.m. licensed practical nurse (LPN)-A came down the hall to rinse out the nebulizer. LPN-A indicated R19 was able to independently self-administer the DuoNeb after the nurse set up the nebulizer treatment. LPN-A was unaware if an assessment or physician order was in place for R19 to self-administer the nebulizer treatment. At 11:12 a.m., LPN-A verified there was no physician order present. LPN-A verified the assessment would be	F 176	F176 R19 was assessed and deemed safe to self administer his nebs. Txs. after the nurse sets up the tx. A physician's order was issued to allow this. All other resident orders were checked for self adm. of meds. None were found. future residents will be assessed and physician's order will be obtained. Will be monitored monthly when the chg.nurse proofs the MARs for the next month.	2/1/13

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F 176	Continued From page 5 completed if the physician ordered to self-administer. LPN-A verified no self-medication assessment was completed. During observation on 1/17/13, at 10:45 a.m. LPN-C went into R19's room and set up DuoNeb nebulizer treatment. LPN-C placed mask with DuoNeb on R19's nose and mouth and said "I will see you a little bit later" and left the room. LPN-C indicated the mask for the nebulizer was to be left on for 10 minutes than then would have been taken off. During interview on 1/17/13, at 10:59 a.m. LPN-C verified R19 had not had an assessment for self-administration. LPN-C verbalized she did not know a resident needed an order or an assessment completed to self-administer medications. During interview on 1/15/13, at 12:25 p.m. the director of nursing (DON) verified there was no self-administration assessment completed. DON said she just forgot. During undated policy review titled SELF-ADMINISTRATION OF MEDICATIONS indicated under section C, the interdisciplinary team determined the resident's ability to self-administer medications by means of a skill assessment conducted periodically based on facility policy.	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225		

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F 225	Continued From page 6 mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to immediately report allegations of	F 225	F225 The DON has reviewed the reportable incident guidelines. She will reinservice her licensed nurses on the guidelines, use of incident reports, and procedure for reporting the incidents to the Administrator and State agency. This will assure that the care of Resident #19 (#29 is deceased) is appropriate, free from potential abuse and/or neglect and prevent future incidents of this kind. Approaches have been added to R#19's care plan to address problems that led to the incident of 11/18/12. [redacted] Director of Nursing, is responsible for the implementation of this plan. The inservicing will be completed by 2/28/2013.	2/28/13 2/26/13 sPM

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F 225	Continued From page 7 abuse to the administrator and State agency, and to complete a thorough investigation for all alleged abuse incident for 2 of 3 residents (R19 and R29) reviewed for abuse protocol. Findings include: R19 had received bruising after nursing assistant (NA)-E held R19's arms during a verbal and physical altercation and when bruising was found the next day the incident had not been reported immediately to the administrator or to the state agency. R19 was admitted on 9/6/11, with diagnoses that included but not limited to Alzheimer's disease and neurotic disorder generalized anxiety disorder. R19's quarterly Minimum Data Set (a resident assessment and care screening tool) dated 12/18/12, indicated R19 had moderate cognitive impairment, delusions and no behavioral symptoms. Review of R19's care plan last updated 12/20/12, indicated under problem "can be abusive" approaches were to monitor for symptoms of abuse toward others or him, intervene, investigate, treatment and report. During interview on 1/14/13, at 1:45 p.m. R19 indicated there had been an incident where he had to quit playing cards to have his toe nails trimmed. R19 indicated staff had other residents go ahead of him and as he left NA-E got me and threw me up against the wall and bruised my hand. R19 confirmed NA-E had not touched him since. During review of the Nurse's Notes dated 11/8/12 at 11:30 p.m. R19 was waiting in hallway to be	F 225		

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F 225	Continued From page 8 seen by the podiatrist. He went into the room to be seen by the podiatrist and saw a female patient was there first. Resident got mad and stormed out of the room. In the process of storming out he yelled and raised his fist at NA-E. NA-E asked R19 if he would come to a quiet place to talk about it. R19 did go into another room and stated, "All the staff here are horses asses, staff is all out to get him and no one does anything to help him." He was reassured that the staff was doing what was best for him and he shook his fist at NA-E and stated "We [staff] were damn liars" and then kicked nursing assistant in his right leg. R19 hen went back into the hallway and tried to trip NA-E. At this item NA-E grabbed his arms firmly and held them until R19 calmed down. During further review of Nurse's Notes on 11/9/12, at 10 a.m., It was noted that resident had visible bruising were NA-E's fingers had grabbed his forearms on the previous day. During interview on 1/15/13, at 12:34 p.m. the director of nursing (DON) indicated she was aware of the incident with R19 and NA-E and had not felt it was reportable to the administrator or to the state agency as the incident was witnessed by staff. During interview on 1/17/13, at 7:39 a.m. the Administrator verified he was unaware of the 11/8/12 incident of being held by staff which caused bruises on arms for R19. He also said that he should have been contacted by the staff and then he would have reported it immediately to state agency. On 1/17/13, at 10:45 a.m. the DON verified no incident report had been completed on the	F 225		

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F 225	Continued From page 9 11/8/12 incident and verified there was no internal investigation completed. R29 was found on 3/28/12 to have bruising on the inner thigh that met the definition for a bruise of unknown origin however; the facility had not immediately reported the incident to the administrator and waited two days to report the incident to the state agency. R29 was admitted on 10/4/11, with diagnoses that included but not limited to senile dementia and Alzheimer's disease. R29's significant status change Minimum Data Set (MDS) revealed R29 had short and long term memory problems and dependent on staff for all activities of daily living skills. During review of Nurse's Notes dated 3/29/12, at 9 a.m. written by the DON, indicated staff reported R29 had a large bruise on inner upper left thigh which extending to the posterior of leg and down the leg to the knee, had denied pain when leg was palpated, no one today knows of any "bumps" to the left leg, had been informed by staff they had noticed a noticed a small light colored bruise yesterday afternoon which was located on R29's thigh and staff felt it may have been from R29 swinging leg back and forth hitting the bed's metal frame as R29 bruises easily. Nurses notes at 6:30 p.m. on 3/29/12 said that R29 had been taken to the emergency room today and on returning it was learned that R29 had a distal fracture of the left femur. During interview on 1/15/13, at 3:08 p.m. the DON said, the initial bruising for R29 had been first observed by staff had been on 3/28/12, the	F 225		

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F 225	Continued From page 10 R29 had been seen in emergency room on 3/29/12 and found to have had a fracture of the leg. The DON then said that she reported the fracture to the state agency on 3/30/12.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop and implement written policies regarding abuse and neglect prevention related to immediate notification of the administrator and the State agency for 2 of 3 residents (R19 and R29) reviewed for allegations of abuse. Findings include: The facility's abuse and neglect policy, "Vulnerable Adult Policy and Procedure" did not specifically state that all violations of abuse, neglect or injuries of unknown origin, needed to be immediately reported to the facility Administrator and State agency (Office of Health Facility Complaints). On 1/15/13, at 10:00 a.m. the facility provided their policy titled, Ostrander Nursing Home Vulnerable Adult Policy and Procedure (undated), which included under section A- "REPORTING"	F 226		

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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
F 226	Continued From page 11 the following: "A mandated reporter as defined in Exhibit A, who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information internally to the Administrator or DNS [director of nursing services] or his/her designee." Under section B. the following was written "The results of all investigations must be reported to the Administrator or his/her designee and to the appropriate State agency, as required by State law, within 24 HRS of the alleged violation VIA ELECTRONIC NOTIFICATION ON THE WEB." The policy did not clearly identify that the administrator and State agency should be contacted immediately regarding allegations of abuse/neglect. During interview on 1/17/13, at 12:09 p.m. the Administrator verified the facility's Vulnerable Adult Policy and Procedure directed staff to immediately report the information internally to the Administrator or to the DON. R19 had received bruising after nursing assistant (NA)-E held R19's arms during a physical altercation on 11/8/12. This incident had not been reported immediately to the administrator or to the State agency. During review of the Nurse's Notes dated 11/8/12 at 11:30 p.m. R19 had become upset over other residents being taken in to see the podiatrist and started to yell and kick at staff. NA-E held R19 ' s arms to prevent injury to self and other residents. Nursing notes date 11/9/12 at 10 a.m. noted bruising was found on the arms of R19 where	F 226	**F226** The facility's Vulnerable Adult Policies and Procedures are being revised to: --Include sections on *Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting Response.* --Include specific language on the required Immediate Notification of the Administrator and the Minnesota Department of Health when potential abuse and/or neglect are suspected. --A checklist has been developed to serve as a Tickler File to assure that all necessary tasks, including proper notification of appropriate persons, are carried out. --Any particular problems identified as safety-related issues shall be reported to the Safety Committee and the Quality Assessment and Assurance Committee. --A mandatory in-service for all staff has been scheduled for Feb. 28th, to present the revised Vulnerable Adults Policies and Procedures. [redacted] Admistrator, is responsible for the implementation of this plan.	2-1-13

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	245464	A. BUILDING _____ B. WING _____	01/17/2013

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F 226	Continued From page 12 NA-E had held both arms the day before. During interview on 1/15/13, at 12:34 p.m. the director of nursing (DON) indicated she was aware of the incident with R19 and NA-E and had not felt it was reportable to the administrator or the state agency as the incident had been witnessed by staff. During interview on 1/17/13, at 7:39 a.m. the Administrator indicated he had not been notified of the incident with bruising for R19 and if he would have been contacted it would have been reported to the state agency as it was a reportable incident. R29 was found on 3/28/12 to have bruising on the inner thigh that met the definition for an allegation of abuse however; the incident had not been immediately reported to the administrator or to the State agency. The incident was reported to the State agency on 3/30/13 which was two days after the bruising was found. During review of " Nurse ' s Notes" dated 3/29/12, at 9 a.m. written by the DON indicated staff reported to DON that R29 had a large bruise on inner upper left thigh extending to the posterior of leg and down the leg to the knee and was noted to have a small bruise in the area yesterday which the NA felt it was from lying on side and hitting the bed frame with leg. Nurses notes 3/29/12 at 6:30 p.m. noted the resident had been seen at the emergency room, returned to facility and had a fractured femur. The DON reported this finding to the state agency on 03/30/12. During interview on 1/15/13, at 3:08 p.m. the	F 226		

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F 226	Continued From page 13 DON indicated R29's bruising had been submitted on 3/30/12 to the State agency. The DON said, the initial bruising for R29 had been first noted on 3/28/12 then R29 had been sent to the emergency room in the afternoon of 3/29/12 and found to have had a fracture. DON then said that she is the only one who submits the reportable allegations to the Office of Health Facility Complaints.	F 226		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to invite family and resident to	F 280	**F280** The facility's Care Planning Policies & Procedures have been revised to assure that residents are afforded the right to participate in care planning and/or shall be consulted about care and treatment changes. ---The Director of Nursing coordinates care planning. ---An Interdisciplinary Care Team member, the Dietary Manager, shall invite the resident and/or appropriate family member to the care conference. ---The Director of Nursing and the Dietary Manager replace one another during absences in handling their respective scheduling and invitation tasks. [ ] Director of Nursing, is responsible for the implementation of the facility's Care Planning Policies and Procedures.	4/31/13

OSTRANDER CARE & REHAB
305 Minnesota Street
Ostrander, MN 55961

CARE PLANNING

Policy: Residents shall be afforded the right to participate in care planning or shall be consulted about care and treatment changes.

Procedure:

1. **The DON is the Care Plan/ MDS Coordinator. She sets up the schedule for both according to Federal Regulations.**
2. The Director of Nursing shall provide a copy of the Care Planning schedule to the Dietary Manager who is a member of the IDCT.
3. The Dietary Manager shall invite the resident and/or appropriate family member to the care conference via letter, phone, or in person.
4. The Dietary Manager 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 Dietary Manager 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 DON the Dietary Manager will schedule the Care Plan Conferences. And in the absence of the Dietary Manager the DON will issue the invites

REVIEW DATE INITIALS	Revised Jan. 2013					

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F 280	Continued From page 14 participate in care conference for 3 of 3 residents (R22, R18, and R21) reviewed for participation in care planning. During an interview on 11/14/13, at 4:20 p.m. R22's family representative (F)-A, who was also the resident's power of attorney and health care decision maker, was asked if he was invited to participate in R22's care planning conferences? F-A verified he had not been invited to a care conference. F-A stated he does not receive a notice from the facility to inform R22 of upcoming care conferences. R22 had a diagnosis of senile dementia and was admitted on 8/19/12. Review of the resident's INTERDISCIPLINARY PLAN OF CARE dated 9/8/12 and 11/15/12 revealed the resident's family had not attended the care conference. R18 had diagnoses of Alzheimer's disease and depression and was admitted on 9/13/11. Review of resident's INTERDISCIPLINARY PLAN OF CARE revealed last care conference was held 1/8/13 with no evidence of family or resident attending or having been invited to attend the care conference. R21 had diagnoses of mild cognitive impairment and cerebrovascular disease (stroke) and was admitted on 8/22/12. During review of resident's INTERDISCIPLINARY PLAN OF CARE revealed care conference was held on 9/5/12 and 11/15/12 and no evidence of family or resident present or having been invited to attend the care conference.	F 280		

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F 280	Continued From page 15 During interview on 1/15/13, at 9:49 a.m. the director of nursing (DON) verified the facility had fallen behind on inviting family and residents to care conferences. DON indicated she tried to get the regular visitors when they come in to attend the care conference.	F 280		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 329	F329 & F428 BM med. parameters of use have been added to the physician orders & MARs for R2, R6, & R26. All residents were monitored for missing parameters and they were added to their orders. All MARs printed for March will reflect the parameters. The Consultant Pharmacist has been asked to monitor for parameters and notify DON if they are missing on resident orders. DON will monitor the pharmacy monthly reports for parameters. The licensed staff will monitor MARs monthly for these parameters when new MARs are proofed for use. DON will monitor also on a monthly basis.	2/11/13

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F 329	Continued From page 16 facility failed to develop adequate parameters for use of bowel medications for 3 of 10 residents (R2, R26, and R6) reviewed for unnecessary medications. Findings include: R2 received as needed (PRN) Senna S (a medication used for constipation) without parameters for use. R2 was admitted to the facility on 2/04/04, with diagnoses that included anxiety and pre-senile brain disease. Review of the quarterly Minimum Data Set (MDS) dated 12/10/12, identified R2 as moderately cognitively impaired, rarely or never understood. Record review revealed that R2 had a physician order dated 6/29/11, for Senna S 1-3 tabs per nurses judgment, PO (by mouth) QD (daily) PRN for constipation. The order did not provide parameters for when to give one, two or three tablets. Review of R2's Medication Administration Record (MAR) for the month of January 2013, revealed instructions to give PRN Senna S if no stool in 48-72 hours. The instruction had not identified indications of when to give one, two or three tablets for the 48 or 72 hours. Further review of the MAR indicated that R2 had received the PRN Senna daily, alternating between two and three doses. Review of R2's medical record revealed no documentation that identified how each nurse determined the indication for use of two or three tablets.	F 329		

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F 329	Continued From page 17 R26 received Senna S daily without parameters for use. R26 was admitted to the facility on 12/15/12, with diagnoses that included Alzheimer's dementia, and chronic constipation. Review of the admission MDS dated 12/28/12, identified R26 as having severe cognitive impairment. Record review revealed that R26 had a physician order dated 12/19/12, for Senna S 1-2 tabs per nurse judgment and bowel movement record QD for constipation. The order did not provide parameters for when to give one or two tablets. Review of R26's MAR for the month of January 2013, revealed that R26 had received alternating doses of one and two tablets of Senna S daily. Review of R26's medical record revealed no documentation that identified how each nurse determined the indication for use of one or two tablets. The DON verified during interview on 1/17/13, at 1:25 p.m. that R2 and R26's medical records lacked written parameters for Senna S, and lacked nursing documentation that identified the reason for administering one or more tablets during the month of January 2013. During interview on 1/17/13, at 1:25 p.m. the DON reported when an order gives direction to use nursing judgment it is up to the nurses, including LPN's to make the decision of what dose to give according to their nursing judgment. DON stated, "They are nurses, they can use their judgment." DON stated, "My nursing judgment would be if they went 2 days without a BM [bowel	F 329		

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F 329	Continued From page 18 movement] I would give 2 but that's not written anywhere." During interview on 1/17/13, at 2:50 p.m. the consultant pharmacist verified PRN Senna S orders with the direction to use nursing judgment when deciding dose was not appropriate parameters for use stating, "the PRN parameters for bowel medication does not give clear direction, they need to be more specific, more defined." R6 received the medication Senna S (used to prevent constipation). There were no parameters identified for what dosage of Senna S to use. R6's physician orders were reviewed. R6 had current physician order dated 11/1/10 to use Senna S 1-3 tablets by mouth (PO) per nurse's judgment and bowel record to prevent constipation every day (QD). The physician orders lacked parameters or direction for how many tablets to administer. R6's care plan dated 11-9-12 identified that R6 had "chronic constipation with a history of impaction per H&P [history and physical]." The care plan approaches included: Administer bowel medications as ordered. Keep record of bowel movements. Monitor for fecal impaction. Reviewed medication administration record (MAR) from January 1, 2013 to January 15, 2013. The MAR revealed R6's had received Senna S and the dosing ranged from 1 to 3 tablets. During an interview on 1/17/13 at 7:15 a.m. licensed practical nurse (LPN)-C stated the MAR	F 329		

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F 329	Continued From page 19 instructed the nurses to review the bowel monitoring record and to use nursing judgment to decide which dosage of Senna to give residents. LPN-C verified the current physician's order on the MAR lacked parameters to identify which specific dose of Senna should be administered. During an interview on 1-17-13 at 11:19 a.m. the director of nursing (DON) when asked if the physician orders for the Senna S should include parameters, responded the staff are to use nursing judgment and to review the bowel monitoring records to determine what dose of Senna to use for the residents. The DON responded what else would you do. The DON stated the pharmacist does identify orders that lack parameters during the medication regimen reviews. The facility did not have a policy and procedure for parameters of medications.	F 329		
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 354	F354 We will assure that we have an RN on duty for 8 hrs. 24/7. The situation that arose was that we only have 3 RNs on staff and none could work that day. The DON was on call as always. We have been advertising since July 2012 for an RN with no applicants. We continue to advertise. We are considering applying for an RN waiver. The DON will monitor the schedule weekly.	2-26-13 DON ongoing

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F 354	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 8 hours of registered nurse coverage every day for seven days a week This had the potential to affect 18 of 18 residents. Findings include: The facility lacked eight hours registered nurse coverage on 12/23/12. During the extended survey review of the actual nursing schedule for 12/13/12 -1/9/13, revealed no registered nurse coverage on 12/23/12. During interview on 1/17/13, at 3:00 p.m., the director of nursing verified there was no registered nurse who worked on 12/23/12. Director of nursing verified the facility did not have a waiver for registered nurse coverage. Director of nursing stated it was the holiday and difficult to find registered nursing staff.	F 354		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides.	F 356		

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F 356	Continued From page 21 o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post required staffing information which included actual hours worked. This had the potential to affect all 18 of 18 residents. Findings include: Observations during the initial facility tour on 1/14/13, at 12:45 p.m., revealed the staffing information posted was dated 1/14/13, and identified facility census of 18. The staffing information included all three shifts, licensed and unlicensed staff, and total hours worked. However, there was no actual hours worked for each discipline.	F 356	F356 Our nursing hours form has been amended to document our projected & actual hrs. over a 24 hr. period. The Nsg. Adm. Asst. is responsible for this procedure. DON will monitor.	2/1/13

OSTRANDER CARE & REHAB

REPORT OF NURSING STAFF DIRECTLY
RESPONSIBLE FOR RESIDENT CARE

DATE: _____

CURRENT CENSUS: _____

SHIFT	#RNS/HRS PROJECTED/ ACTUAL	#LPNS/HRS PROJECTED/ ACTUAL	#CNAS/HRS PROJECTED/ ACTUAL
DAY	____/____	____/____	____/____
EVE.	____/____	____/____	____/____
NIGHT	____/____	____/____	____/____
TOTALS	____/____	____/____	____/____

TOTAL OF ALL HOURS ____/____

Daily posting of this information is required for all
Facilities participating in Medicare and Medicaid.

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F 356	Continued From page 22 During interview on 1/17/13, at 3:00 p.m., the director of nursing verified the staffing information posted for 1/14/13, did not include actual hours worked.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the consultant pharmacist identified the lack of adequate parameters for use of bowel medications for 3 of 10 residents (R2, R26, R6) reviewed for unnecessary medications. Finding Included: R2 received as needed (PRN) Senna S (a medication used for constipation) without parameters for use. R2 was admitted to the facility on 2/04/04, with diagnoses that included anxiety and pre-senile brain disease. Review of the quarterly Minimum Data Set (MDS) dated 12/10/12, identified R2 as moderately cognitively impaired, rarely or never	F 428	Please see F329 POC. It includes POC for this tag. Daily Living Dev 2-13-13	02/11/13

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F 428	Continued From page 23 understood. Record review revealed that R2 had a physician order dated 6/29/11, for Senna S 1-3 tabs per nurses judgment, PO (by mouth) QD (daily) PRN for constipation. The order did not provide parameters for when to give one, two or three tablets. Review of R2's Medication Administration Record (MAR) for the month of January 2013, revealed instructions to give PRN Senna S if no stool in 48-72 hours. The instruction had not identified indications of when to give one, two or three tablets for the 48 or 72 hours. Further review of the MAR indicated that R2 had received the PRN Senna daily, alternating between two and three doses. Review of R2's medical record revealed no documentation that identified how each nurse determined the indication for use of two or three tablets. R26 received Senna S daily without parameters for use. R26 was admitted to the facility on 12/15/12, with diagnoses that included Alzheimer's dementia, and chronic constipation. Review of the admission MDS dated 12/28/12, identified R26 as having severe cognitive impairment. Record review revealed that R26 had a physician order dated 12/19/12, for Senna S 1-2 tabs per nurse judgment and bowel movement record QD for constipation. The order did not provide parameters for when to give one or two tablets. Review of R26's MAR for the month of January	F 428		

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	245464	A. BUILDING _____ B. WING _____	01/17/2013

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

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F 428	Continued From page 24 2013, revealed that R26 had received alternating doses of one and two tablets of Senna S daily. Review of R26's medical record revealed no documentation that identified how each nurse determined the indication for use of one or two tablets. The DON verified during interview on 1/17/13, at 1:25 p.m. that R2 and R26's medical records lacked written parameters for Senna S, and lacked nursing documentation that identified the reason for administering one or more tablets during the month of January 2013. R6 received the medication Senna S (used to prevent constipation). There were no parameters identified for what dosage of Senna S to use. R6's physician orders were reviewed. R6 had current physician order dated 11/1/10 to use Senna S 1-3 tablets by mouth (PO) per nurse's judgment and bowel record to prevent constipation every day (QD). The physician orders lacked parameters or direction for how many tablets to administer. R6's care plan dated 11-9-12 identified that R6 had "chronic constipation with a history of impaction per H&P [history and physical]." The care plan approaches included: Administer bowel medications as ordered. Keep record of bowel movements. Monitor for fecal impaction. Reviewed medication administration record (MAR) from January 1, 2013 to January 15, 2013. The MAR revealed R6's had received Senna S and the dosing ranged from 1 to 3 tablets. During an interview on 1/17/13 at 7:15 a.m.	F 428		

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F 428	Continued From page 25 licensed practical nurse (LPN)-C stated the MAR instructed the nurses to review the bowel monitoring record and to use nursing judgment to decide which dosage of Senna to give residents. LPN-C verified the current physician's order on the MAR lacked parameters to identify which specific dose of Senna should be administered. During interview on 1/17/13, at 2:50 p.m. the consultant pharmacist verified PRN Senna S orders with the direction to use nursing judgment when deciding dose was not appropriate parameters for use stating, "the PRN parameters for bowel medication does not give clear direction, they need to be more specific, more defined."	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		

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F 441	Continued From page 26 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included surveillance and investigation of infections that occur in the facility, track employee infections, and maintain accurate and comprehensive records at the time the infection occurred. This had the potential to affect all 18 residents in the facility, staff and visitors. Findings include: The facility's infection control program (ICP) did not include the necessary components to track, trend and analyze infections. The facility's ICP logs from 1/3/12, to 1/9/13, were reviewed and it was noted that the facility had not identified residents with illnesses were located in	F 441	**F441** **The Surveillance & Monitoring Chapter of our IC Manual was reviewed by the DON. The policies & procedures in this chapter will be followed to cover the areas cited on our survey. The infection list our nurses compile at time of illness will be checked Mon-Fri. by DON. The info. will be transferred to the IC Control Log for assessment of clusters & repeat infections, to delineate nosocomial vs. community infections, causative organism,tx., resolution. The data will be analyzed weekly & monthly to i.d. trends & determine corrective action to prevent the spread of disease. Outbreaks of serious illness, both resident & staff, will be reported to the Med. Director when noted. Employee illness is now being tracked on occurerence and analyzed by the DON/ICP. Staff & resident illnesses will be reviewed at QAA. The process will be monitored by Nsg. Adm. Asst. monthly.** 2/1/13 + ongoing	

MONTHLY ANALYSIS OF RESIDENT INFECTIONS

JAN. 2013

There were 5 infections in January. 4 were respiratory; none progressed to influenza or pneumonia. All resolved without complication. The other infection was a L.leg cellulitis in a gentleman with a diagnosis of T2DM & peripheral vascular disease. We had 2 employee illnesses-one was respiratory; the other was gastroenteritis. Both were absent during their illnesses. It is winter & flu season in Minnesota. The resident resp. illnesses were not clustered either. We've been vigilant about monitoring for sx. and handwashing to prevent infections. D.Leibold, DON

OSTRANDER CARE & REHAB
305 Minnesota Street
Ostrander, MN 55961

Policy: Employee Health Status Report

Name:_____ Dept._____
Date & time:_____ Shift:_____

Procedure:

1. **Absence slips from ALL DEPARTMENTS will be turned in to the DON/ICN. This form will be completed by the DON. If an employee is ill while on duty the charge nurse will evaluate and fill out #2-5. Vital signs will be taken and sx. reviewed. The nurse will decide whether the employee needs to be sent home or continue working with precautions i.e. wearing a mask. The form will be turned in to the DON to complete. The Nsg. Adm. Asst. will file it in the employee health file. The DON, who is the IC Nurse also, will maintain a log of the illnesses for review at QAA. If an acute outbreak occurs the Medical Director will be notified. The MDH will be notified per the guidelines in our Infection Control Manual.**
2. **Date when sx. are noted or called in**_____
3. **Symptoms:**_____
   _____
4. **Type of infection suspected:**
   _____ **Gastric/intestinal** _____ **Skin**
   _____ **Respiratory** _____ **Eye**
   _____ **Wound** _____ **Unknown**
   _____ **UTI**
5. **Precautions used:**_____
   Sent home_____
6. Person taking the call:_____ Date:_____
7. Seen by physician /date:_____
8. Antibiotic:_____
   Culture:_____
9. Return towork date & VS_____

Comments:_____
_____
_____

Employee signature/date:_____
DON or charge nurse signature/date:_____
dal 2013

Rev'd	Year	Year	Year	Year	Year	Year	Year

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F 441	Continued From page 27 the facility to determine clusters, nor had the facility identified residents with repeated infections. The facility had not consistently identified the causative organism, the treatment provided, or whether the infections were acquired in house or from the community. Further, the facility had no documentation that they had analyzed data or identified trends to determine corrective action to prevent the spread of the infections. The facility was unable to provide any further logs or tracking tools for infections in the facility and was unable to provide documentation that they had tracked staff illness. During interview on 1/15/13, at 12:45 p.m. director of nursing (DON) who was identified as the infection control nurse indicated that she did not track and/or trend infections while infections were ongoing, stating the infection control logs were filled in at the end of each month. DON confirmed the lack of documentation of specific organisms in the ICP logs, and stated specific organisms were not tracked or documented on the log because "We don't get them back right away." DON stated she writes a note at the top of the log to look in the laboratory section of the chart for organisms. DON verified the infection control surveillance program lacked tracking and trending of specific organisms, analysis of repeated infections, identification of where the residents were located in the facility, and whether the infections were acquired in house or from the community. DON further verified she did not track staff illness. On asking for the policy for their infection control	F 441		

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F 441	Continued From page 28 program the surveyor was given a binder containing multiple ICP policies and the facility did not identify which policy they were currently utilizing.	F 441		

F5464022

PRINTED: 02/05/2013
FORM APPROVED
OMB NO. 0938-0391

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Ostrander Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	POC ok JB 2-11-13	

EXIT: 1/17/13 DC: 2-26-13

RECEIVED
FEB 11 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Loyd L. Swalve	Administrator	2-12-13

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ostrander Nursing Home is a 1-story building, with a partial basement. This facility was constructed in 1968 and was determined to be of Type II(111) construction. This facility is fully sprinklered as 01/04/2013. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 25 beds and had a census of 19 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2.1. The deficient practice could affect all 19 residents. Findings include: On facility tour between 8:30 AM and 10:30 AM on 01/16/2013, the review of the annual fire alarm system inspection / test was not completed in a 12 month period. The report from Per Mar indicated the 2012 was completed on 10/09/2012 and 2011 was completed on 10/04/2011. This deficient practice was confirmed by the Facility Maintenance Director (TF) at the time of discovery.	K 054	**K054** The facility assures that the facility fire alarm system will be maintained in accordance with the required 1999 NFPA 72, Section 7-3.2.1. The annual fire alarm inspection/test will be conducted within a 12-month period. Tom Frederick, Maintenance Director, will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	2-13-13
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff	K 069	**K069** The facility assures that the kitchen cooking hood fire extinguishing system will be maintained in accordance with 2000 NFPA 101 – 9.2.3 and 1998 NFPA 96 section 8.2	

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K 069	Continued From page 3 interview, the facility's kitchen cooking hood fire extinguishing system was not maintained in accordance with 2000 NFPA 101 - 9.2.3 and 1998 NFPA 96 section 8.2.. This deficient practice could affect all 19 residents. Findings include: On facility tour between 8:30 AM and 10:30 AM on 01/16/2013, the review of the kitchen hood system inspection documentation for the past 12 months revealed that the kitchen hood was not inspected every 6 months (03/19/2012 and 09/26/2012). This deficient practice was confirmed by the Facility Maintenance Director (TF) at the time of discovery.	K 069	CONTINUED by requiring that the hood be professionally inspected every six months. Tom Frederick, Maintenance Director, will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	2-13-13
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110	K 144	**K144** The facility assures future compliance in accordance with NFPA 99.3.4.4.1, 2000 NFPA 101 – 9.1.3, and 1999 NFPA 110, Chpt. 6-4.1. Weekly operational inspections of the emergency generator shall be conducted, and documented in weekly inspection logs. Tom Frederick, Maintenance Director, will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	2-13-13

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K 144	Continued From page 4 Chapter 6-4.1. The deficient practice could affect all 19 residents. Findings include: On facility tour between 8:30 AM and 10:30 AM on 01/16/2013,the documentation review of the weekly inspection logs (January 2012 to December 2012) for the diesel emergency generator revealed that a weekly operational inspections were missed for the weeks of 05/28, 07/23, and 09/24/2012. This deficient practice was confirmed by the Director of Maintenance (TF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		