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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M7TN

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 **03/29/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Danette Bakken HFE NE II 8/8/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/30/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00040** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245464

August 30, 2017

Mr. Grant Thayer, Administrator
Ostrander Care And Rehab
305 Minnesota Street
Ostrander, MN 55961

Dear Mr. Thayer:

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 March 24, 2017 the above facility is certified for:

25 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245464

June 30, 2017
By Certified Mail

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

Dear Ms. Rauk:

SUBJECT: SURVEY RESULTS AND IMPOSITION OF CIVIL MONEY PENALTY
Cycle Start Date: January 6, 2017

SURVEY RESULTS

On January 4, 2017, a Life Safety Code (LSC) survey was completed at Ostrander Care and Rehab by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey revealed that your facility was not in substantial compliance and found the most serious deficiency to place the health and safety of your patients in immediate jeopardy. This deficiency was cited as follows, including the level of Scope and Severity (S/S):

- K918 -- S/S: L -- NFPA 101 -- Electrical Systems – Essential Electric System

Surveyors found a situation of immediate jeopardy to patient health and safety that was removed on March 6, 2017. However, they also found that your facility continued not to be in substantial compliance with Federal requirements, with them most serious deficiencies cited as follows:

- K712 -- S/S: F -- NFPA 101 -- Fire Drills
- K781 -- S/S: F -- NFPA 101 -- Portable Space Heaters

On January 6, 2017, the MDH conducted a health survey at your facility. This survey also revealed that your facility was not in substantial compliance with the most serious deficiency cited as follows:

- F314 -- S/S: G -- 483.25(c) -- Treatment/Svcs to Prevent/Heal Pressure Sores

On March 2, 2017, the MDH conducted a revisit of your facility. The revisit revealed that your facility continued to not be in substantial compliance with the most serious deficiencies cited as follows:

- F279 -- S/S: D -- 483.20(d);483.21(b)(1) -- Develop Comprehensive Care Plans
- F314 -- S/S: D -- 483.25(b)(1) -- Treatment/Svcs to Prevent/Heal Pressure Sores
- F323 -- S/S: D -- 483.25(d)(1)(2)(n)(1)-(3) -- Free of Accident Hazards/Supervision/Devices

The MDH advised you of the deficiencies noted above and provided you with a copy of the survey reports (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the MDH notified you on January 23, 2017, of the imposition of the following remedies, as well as your appeal rights:

- State Monitoring effective January 28, 2017
- Mandatory denial of payment for new admissions effective April 6, 2017

The MDH notified you they were recommending that the CMS impose additional remedies, as follows:

- Federal Civil Money Penalty
- Mandatory termination effective July 6, 2017

The authority for the imposition of remedies is contained in §1819(h) and §1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488, Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

On March 29, 2017, the MDH conducted another revisit of your facility. This revisit found that your facility was in substantial compliance as of March 24, 2017. As a result, the final status of remedies is as follows:

CIVIL MONEY PENALTY
On September 6, 2016 the Department of Health and Human Services (HHS) published an Interim Final Rule in the Federal Register which adjusts for inflation CMP amounts authorized under the Social Security Act. ***See*** **45 CFR Part 102**. In determining the amount of the Civil Money Penalty (CMP) that we are imposing, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR §488.404. We are imposing the following CMP:

- Federal Civil Money Penalty of $11,397 per instance for the instance on January 4, 2017 described at deficiency K918 (S/S: L)
- Federal Civil Money Penalty of $3,702 per instance for the instance on January 6, 2017 described at deficiency F314 (S/S: G)

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted electronically to Tamika J. Brown at Tamika.Brown@cms.hhs.gov within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the CMP

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification at RO5LTCHearingWaivers@cms.hhs.gov. **Please include your CCN and the Cycle Start Date in the subject line of your email.**

The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.

CMP CASE NUMBER

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is **245464**
- The start date for this cycle is **January 6, 2017**

CMP PAYMENT

When due, the CMP is payable by check to CMS at the following address:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
Post Office Box 7520
Baltimore, MD 21207

If you use a delivery service, such as Federal Express, **use the following address only**:

Centers for Medicare & Medicaid Services
Division of Accounting Operations
Mail Stop C3-11-03
7500 Security Boulevard
Baltimore, MD 21244

Note that your check must be sent to one of the above addresses--not to the Chicago Regional Office. If the total amount of the CMP is not received by the due date, interest will be assessed in accordance with the regulations at 42 CFR § 488.442 on the unpaid balance of the penalty beginning on the due date. The Federal rate of interest is 10%. The CMP, and any interest accrued after the due date, will be deducted from sums owing to you **without any further notification from this office.**

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) and Nurse Aide Competency Evaluation Programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

As indicated above, a CMP which to date has accrued in the amount of $10,483 or more, is being imposed against Ostrander Care and Rehab, therefore, this provision is applicable to your facility. If you fail to request a hearing, in writing, within 60 calendar days from receipt of this letter; or if you submit a written waiver of your right to a hearing, which results in the CMP being reduced to an amount that is still $10,483 or more; or if you timely request a hearing and there is a final administrative decision upholding the CMP in the amount of $10,483 or more, your facility is subject to a NATCEP prohibition for two years. The two-year prohibition will be effective, as applicable, with: (1) the expiration of the 60-day period for filing a written request for a hearing; or, (2) the receipt of your written waiver of the right to a hearing within the specified time period; or (3) the date of the final administrative decision upholding the CMP in the amount of $10,483 or more. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the

MDH and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed a CMP. If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR §498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB EFile, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB EFile is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

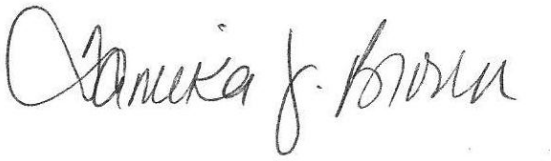
INFORMAL DISPUTE RESOLUTION
The MDH offered you an opportunity for Informal Dispute Resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)
In accordance with 42 CFR §488.431, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, 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 (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to: www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

CONTACT INFORMATION

If you have any questions regarding this matter, please contact Tamika J. Brown, Principal Program Representative, at (312) 353-1502. Information may also be faxed to (443) 380-6614.

Sincerely,



Tamika J. Brown
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health
U.S. Department of Justice, District of Minnesota

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M7TN

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(L5) **OSTRANDER, MN** (L6) **55961**

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FISCAL YEAR ENDING DATE: (L35) **12/31**

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

* Code: **B*** (L12)

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

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17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 03/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/08/2017 (L20)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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B. Rescind Suspension Date: (L45)

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OTHER
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30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 14, 2017

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

RE: Project Number S5464028

Dear Ms. Rauk:

On January 23, 2017, we informed you that the following enforcement remedy was being imposed:

- **State Monitoring effective January 28, 2017. (42 CFR 488.422)**

Also, on January 23, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- **Civil money penalty for the deficiencies cited at K918 and F314. (42 CFR 488.430 through 488.444)**

This was based on the deficiencies cited by this Department for a standard survey completed on January 6, 2017. The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On March 2, 2017, the Minnesota Department of Health and on February 16, 2017 the Minnesota Department of Public Safety completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 20, 2017. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 6, 2017. The deficiencies not corrected are as follows:

F0314 -- S/S: D -- 483.25(b)(1) -- Treatment/Svcs To Prevent/Heal Pressure Sores
F0323 -- S/S: D -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/Supervision/Devices
F0356 -- S/S: C -- 483.35(g)(1)-(4) -- Posted Nurse Staffing Information

In addition, at the time of this revisit, we identified the following deficiency:

F0279 -- S/S: D -- 483.20(d);483.21(b)(1) -- Develop Comprehensive Care Plans

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

- **Civil money penalty for the deficiencies cited at K918 and F314, be imposed. (42 CFR 488.430 through 488.444)**

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- **Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 6, 2017. (42 CFR 488.417 (b))**

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 6, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 6, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Ostrander Care And Rehab is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 6, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

The CMS Region V Office will notify you of their determination regarding the imposed and recommended remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)
An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include electronic acknowledgement signature of provider and date.

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

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

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

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

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE
Upon receipt of an acceptable ePoC, 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY
We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	R 03/02/2017

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

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{F 000}	INITIAL COMMENTS An onsite Post Certification Revisit (PCR) was completed on March 1 & 2, 2017, to follow up on deficiencies issued during a recertification survey exited on January 6, 2017. As a result, the following deficiencies were uncorrected: F314, F323, and F356. Also added was F279. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form.	{F 000}		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 279		3/24/17

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

Electronically Signed | 03/22/2017

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F 279	Continued From page 1 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 3 residents (R35) who was dependent in activities of daily	F 279	1. A care plan was developed for R35. It detailed all the needs of the resident. It outlined assistance needed by R35 to meet his needs.	

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F 279	Continued From page 2 living (ADL). Findings include: R35 was admitted to the facility 1/31/17. The admission Minimum Data Set date 2/7/17, identified a Brief Interview for Mental Status of 4 indicating severe cognitive impairment and extensive assistance needed with dressing and grooming. R35's care plan dated 2/28/17 was provided by the assistant director of nursing (ADON) on 3/2/17 at 10:13 a.m. It was one page and identified a problem of fall in recent past. However, no interventions related to R35's need for assistance with activities of daily living which she was assessed as having extensive assistance in this area. On 3/2/17, at 10:13 a.m. the ADON stated that the one page provided was the only care plan that had been developed for R35. The ADON verified that a complete care plan had not been developed for R35. Review of the policy Formulation of Resident Care Plans, with a revised date 7/2016, included, Guideline: Each resident will have a care plan present on his/her chart that provides information for all members of the interdisciplinary care team, regarding guidelines for individualized care. Procedure Guidelines: 5. An interdisciplinary care plan meeting will be held quarterly to review, revise, and update the plan of care. 6. Care plans will be reviewed by licensed staff quarterly.	F 279	2. A review of all care plans was completed on March 15-17 to check for compliance of each care plan 3. Care plans will be developed within the timeframe required under 483.24, 483.25 or 483.40. Care plans will address all the needs of each resident. 4. Audits will be completed by DON/Designee regarding timely completion and thoroughness. Audits will be done weekly for four weeks, quarterly for three times and information will be shared with the QAA Committee on a quarterly basis.	
{F 314} SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	{F 314}		3/24/17

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{F 314}	Continued From page 3 (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services to minimize the risk for further development of pressure ulcers for 1 of 1 resident (R20) reviewed for pressure ulcers. Findings include: On 3/01/17, at 3:03 p.m. R20 was observed seated in a wheelchair (w/c) at the table in the activity area with other residents socializing. R20 did not have shoes on her feet though was wearing non-skid stockings. R20 was then observed to propel self down hallway independently towards the nurses station then back to the table. R20's significant change Minimum Data Set (MDS) assessment dated 1/24/17 included: Brief	{F 314}	1. Measurements and documentation was completed on R20's blister area. Skin monitors were reviewed and updated for R20. 2. All residents were reviewed and skin monitors weekly were set up by nursing if not already in place. Wound monitoring was completed also on 3/3/2017. 3. Education will be provided on pressure ulcers. The need for weekly skin monitoring and the follow through on preventative measures for all staff. This will be completed by 3.24.17. 4. Weekly audits will be done for one month, then quarterly for one year by the DON/Designee and shared with the QAA Committee.	

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{F 314}	Continued From page 4 interview for mental status (BIMS) score of 7 indicating severe cognitive impairment; not at risk for pressure ulcers (pu), one stage 2 pressure ulcer - date: 12/5/16, most severe tissue type for any pressure ulcer (pu) - slough, pu present on prior assessment, extensive assistance with bed mobility, transfer, toilet use, and personal hygiene, limited assist with dressing, independent with locomotion on/off unit and eating. R20's care plan last revised 2/15/17, included: 12/7/16 Problem: (pressure ulcer): impaired skin integrity. 12/7/16 approaches for nurses indicated: skin assessment per policy. Note changes in level of risk for skin breakdown and minimize factors. Identify and minimize exposure to mechanical and chemical skin irritants. Educate resident/family/staff regarding treatment and preventive measures. Administer medications /treatment as ordered and evaluate for effectiveness. Monitor lab values, Note nutrition and hydration status and address sources of deficiency. 12/7/16 - nurse aide - minimize pressure on bony prominences. Report changes to nurse. Use pillows for support, Use moisturizer with cares, Keep skin clean and dry, Keep linen clean, dry, and wrinkle free. Review of R20's weekly skin assessments indicated the following: 2/27/17 at 22:07 (10:07 p.m.) - skin issues notes - sacral area red no open areas noted 1/30/17 at 18:57 (6:57 p.m.) - the res (resident) has an area on the top of her R (right) foot that is being treated daily. No shoe is worn on that foot. Ulcer care application of nonsurgical dressings (with or without topical medications) other than to feet. Dressing changed. 1/19/17 at 15:06 (3:06 p.m.) - *NEW AREA**	{F 314}		

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{F 314}	Continued From page 5	{F 314}		

blister 2.5 cm (centimeters) x (by) 3 cm intact on right heel denies pain/discomfort.

When interviewed on 3/2/17, at 10:55 a.m. the assistant director of nursing (ADON) confirmed R20 previously had an open area on the top of her R foot that had since healed. , ADON stated on 2/27/17 when R20's sacral area was observed reddened on the weekly skin assessment, the resident had previously been sitting in her w/c. R20 was then layed down and when reassessed later the sacral area was no longer red. ADON further stated R20 frequently repositions herself by lifting her seat off w/c independently and also is on a walking schedule to and from meals with staff assistance. ADON was unaware of any further concerns with R20's R heel.

When interviewed on 3/02/17, at 12:51 p.m. registered nurse (RN)-A stated being unaware if R20 had any skin areas of concern that were being monitored as had not completed her weekly skin check in awhile.
RN-A further stated if a skin assessment is due will come up on the electronic "To Do" list as well as the MAR/TAR (medication administration record/treatment administration record) each shift.

On 3/02/17, at 1:03 p.m. R20's R heel was observed with the ADON while resident was seated in her w/c in room. R20's R heel had a circular reddish/pink area on the bottom of the heel with dry flaky skin around the edges; the skin was intact. ADON measured the area which was 3 cm x 4 cm; the ADON then pressed the reddened area on the R heel inward. R20 exclaimed, "Ow!" When the ADON asked R20 if it hurt when she pushed on the R heel R20

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{F 314}	Continued From page 6	{F 314}		

confirmed that it did. ADON confirmed the original blistered area on R20's R heel had not been measured since first identified on 1/19/17. ADON further stated the physician was notified of the blister when first identified and staff were told just to monitor the area. ADON was unsure if the skin on R20's R heel had ever been open. ADON confirmed the heel was not being monitored as a pressure ulcer and could not say why. ADON stated R20 no longer wears shoes per the family as the previous open area (now healed) on top of R20's R foot was caused by her shoes. ADON indicated R20 now wears non-skid stockings only. ADON stated they try to float R20's heels on pillows but she moves around so much that they don't stay. ADON denied any other interventions other than removal of shoes had been attempted to keep pressure off of R20's heels.

Review of the physician nursing home visit note dated 1/20/17 included: "1. Right foot pressure ulcer, improving. Now with heel blister. This does not appear infected, is not open. We are going to just leave it open to air currently. We are working on seeing what we can do in terms of keeping her feet in a different position, although it is very difficult without making her have worsening symptoms."

When interviewed on 3/2/17, at 1:18 p.m. nursing assistant (NA)-C stated the reddened area on R20's right heel had been there "awhile." NA-C did not ever remember the area being open. NA-C denied any interventions such as floating the residents' heels in bed or the use of heel protectors.

When interviewed on 3/2/17, at 1:31 p.m. NA-A and NA-E each indicated they worked the day

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{F 314}	Continued From page 7 shift. NA-E stated when they came to work in the morning half the time R20's feet were hanging out of the bed or turned sideways. NA-E denied ever being directed to float R20's heels in bed and stated the resident would probably not be cooperative with that anyway. NA-A also denied direction to float R20's heels in bed. Neither NA-A or NA-E were aware of R20's R heel ever being blistered or open. When interviewed on 3/02/17, at 2:10 p.m. the ADON confirmed R20's R heel should have been monitored and measured weekly with the weekly skin checks. The policy titled Pressure Ulcer Policy, reviewed 6/2016 included: 5. Residents having pressure ulcers receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing.	{F 314}		
{F 323} SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	{F 323}		3/24/17

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{F 323}	Continued From page 8 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to complete a comprehensive falls assessment to determine if current falls interventions were appropriate or if new falls interventions needed to be developed for 1 of 2 residents (R35) who had a history of falls. Findings include: R35 was admitted to the facility 1/31/17. The admission Minimum Data Set (MDS) dated 2/7/17, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment and assistance of one staff with transfers. The Care Area Assessment (CAA) for falls identified resident had multiple falls while in the assisted living. He had a fall after his admission to the facility which occurred as he was tying to transfer from his wheelchair into his bed. The CAA identified that R35 was working with physical therapy (PT) to increase strength and had a tab alarm in wheelchair to alert staff if he tries to self transfer (no tab alarm was present). Review of falls history identified R35 had a fall on	{F 323}	1. A comprehensive fall assessment was completed on R35 on 3.2.17. The care plan was reviewed, revised and updated as needed. 2. All residents who were at risk for falls were reviewed and a comprehensive fall assessment was completed on them. Care plans were reviewed and revised as needed. 3. Training will be provided for all staff on fall prevention. Training is also provided on recommendations for steps to be taken, tools necessary for prevention, and the follow through to review for needed changes, if necessary. 4. Audits will be done weekly for one month, quarterly for one year by DON/Designee. Findings will be shared at the QAA Committee Meetings.	

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{F 323}	Continued From page 9	{F 323}		

2/2/17, where resident was found on the floor. Preventative action identified was to educate resident to use the call light light ask for assistance and not transfer self. R35 had another fall on 2/25/17, where R35 was found sitting on the floor and admitted to self transferring. Resident was instructed to call for help. No interventions were identified.

On asking for R35's care plan a one page care plan was provided by the facility on 3/2/17, at 10:13 a.m. The assistant director of nursing (ADON) verified this was the only care plan developed. The care plan problem dated 2/28/17, identified fall in recent past, no goal was identified and approaches dated 2/28/17 were transfer with assistance, instruct to call fro help, anticipate needs and locate near staff when out of bed.

During interview on 3/2/17, at 12:00 p.m., physical therapy assistant (PT)-A stated they were working with R35 on strengthening, standing and transfers. She stated we are discharging him today and recommend he stay here in the facility.

During interview with certified occupational therapy assistant (COTA)-A on 3/2/17, at 12:10 p.m. she stated R35 scored really low cognitively. She stated we can educate on not transferring self but he won't stay put and wait due to his cognition. She stated we are going to recommend using an alarm, that might help. She stated he does not have an alarm on at this time.

Ding interview with the ADON on 3/2/18, at 12:20 p.m. she stated therapy and activities monitor him. He doesn't have any alarms on but I guess we should try that. She verified no interventions had been put into place after R35's falls.

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

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{F 323}	Continued From page 10 The Policy Incident Reports and Follow Up reviewed 5/2016, identified, 2. A post Fall Assessment Form is completed, when appropriate, by the DON (director of nursing or designee. and 3. Patterns are identified and interventions taken as appropriate.	{F 323}		
{F 356} SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	{F 356}		3/24/17

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 _____	R 03/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 356}	Continued From page 11 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. 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. (4) Facility data retention requirements. 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 consistently include current census information, shift hours, and the number of licensed and unlicensed staff worked on the daily nursing hour posting. This had the potential to effect all visitors to the facility in addition to the 21 residents residing in the facility. Findings include: Upon entrance to the facility on 3/1/17, at 12:45 p.m. observation of the facility nursing hour posting did not include the current census, nor did it include the numbers of licensed and unlicensed staff working each shift. In addition, the nursing hour posting did not include the actual times of each shift; shifts were identified as day, eve. (evening), and night.	{F 356}	A new form was developed and completed prior to the exit of surveyors on 3.2.17. Audits will be completed by the DON/Designee to assure accuracy of the form weekly times four weeks and then quarterly times three by the DON/Designee.	

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 _____	R 03/02/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 356}	Continued From page 12 Review of the facility nursing hour postings dated 2/1/17 - 3/1/17 consistently revealed lack of shift times and number of licensed and unlicensed staff working each shift. Review of the nursing schedules dated 2/2/17 - 2/15/17 and 2/16/17 - 3/1/17 revealed the following: day shift hours: 6:00 a.m.- 2:00 p.m.; evening shift hours: 2:00 p.m. - 10:00 p.m.; night shift hours: 10:00 p.m. - 6:00 a.m. The schedules further revealed sporadic other shifts worked including: 2/8/17 - 9:00 a.m. - 5:00 p.m. 2/14/17 - 9:00 a.m. - 7:30 p.m. 2/15/17 - 8:45 a.m. - 6:15 p.m. 2/16/17 - 9:00 a.m. - 6:00 p.m. and 6:00 p.m. - 10:00 p.m. 2/24/17 - 6:00 p.m. - 6:00 a.m. and 2:00 p.m. - 6:00 p.m. 2/28/17 - 4:00 p.m. - 7:00 p.m. When interviewed on 3/01/17, at 2:45 p.m. the administrator confirmed the posting of nursing hours did not include the actual hours of the shifts worked nor the number of each discipline working each shift. The administrator further confirmed there were shorter shifts worked at times and the postings would not include these shifts though would be included in the hours worked.	{F 356}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245464 Y1	A. Building B. Wing Y2	3/2/2017 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280	Correction	ID Prefix F0282	Correction	ID Prefix F0312	Correction
Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed	Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	02/15/2017	LSC	02/14/2017	LSC	02/14/2017
ID Prefix F0354	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.35(b)(1)-(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/20/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	3/14/2017	28651	3/2/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/6/2017

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245464 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/16/2017 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0321	02/03/2017	LSC K0346	02/02/2017	LSC K0354	02/02/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0711	02/07/2017	LSC K0712	01/30/2017	LSC K0781	02/07/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	02/07/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 3/14/2017	SIGNATURE OF SURVEYOR 37008	DATE 2/16/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 1/4/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

May 3, 2017

Marian Rauk
Ostrander Care and Rehab
305 Minnesota Street
Ostrander, MN 55961

RE: OAH Docket 19-0900-34218

Dear Ms. Rauk:

This letter is in response to the Independent Informal Dispute Resolution (IIDR) requested by Ostrander Care and Rehab, Ostrander, MN, regarding one federal deficiency issued as a result of a recertification survey, exit date January 6, 2017. The IIDR was conducted in writing by Administrative Law Judge Jeffery Oxley. The Department received Judge Oxley's recommended decision on April 24, 2017.

Decision

After careful review of Judge Oxley's recommendation and the material submitted to the Judge in support of each party's position, I concur with Judge Oxley's recommendation that tag F314 is affirmed, actual harm that is not immediate jeopardy. Resident 3 (R3) had four wounds which were observed by survey staff and mentioned in the deficiency at F314. Wounds #1 and #3 originated from pressure injury to the skin tissue. Judge Oxley indicates in his recommendation that wounds #2 and #4 may have originated from incontinence, but may have been exacerbated due to unrelieved pressure and may have been more appropriate for review at another tag. Skin conditions that originate from another method of tissue injury, but are aggravated by pressure meet criteria for review under F314, in accordance with the State Operations Manual (SOM). It is MDH's assertion that wounds #2 and #4 worsened due to unrelieved pressure and therefore were properly reviewed and cited at tag F314. My decision is based on the following rationale.

Rationale

Tag F314 requires that, based on the comprehensive assessment of a resident, a nursing facility must ensure that (1) a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

R3 was admitted to the facility on September 12, 2014.R3 was diagnosed as suffering from a major depressive disorder, primary hypertension, and "unspecified dementia without behavioral disturbance (Profound Dementia)" at the time of her admission. Upon admission, the facility provided R3 with a

pressure reduction mattress. R3's caregivers used pillow to position R3 when she "was cooperative with position schedule and devices".

R3's Care Plan in September 2015 indicated she was to receive extensive assistance with repositioning and toileting and noted R3 was incontinent. On October 31, 2016, the facility asked a medical doctor to see R3 due to her decline in status. A report from a visit with R3 noted that R3 suffered from an anxiety disorder but did not note any open areas or pressure ulcers, and on November 11, 2016, R3 was admitted to hospice care. R3 was seen on November 16, 2016 by a medical doctor, where R3's generalized anxiety disorder was noted, but no problems with pressure ulcers were noted.

On November 17, 2016, the facility initiated weekly assessments of R3's pressure ulcers and caregiver notes reflect small open areas on left buttock. On November 21, 2016, R3's caregivers observed two skin wounds, one on her sacrum and another on her lower left buttock. On November 22, 2016, R3's Care Plan was changed to End of Life Care. R3's caregivers were instructed to assess whether R3 was in pain and to administer morphine "as needed for moderate to severe acute pain. In addition, caregivers were to "reposition for comfort."

On November 22, R3's Care Plan noted that R3 was experiencing mixed incontinence and total loss of bowel and bladder control. The Care Plan further instructed nurses to apply barrier cream to buttocks to prevent skin irritation. Nurses were to provide "barrier ointments," to check and change every two hours, and to monitor skin condition. Specific instructions about cares and reporting skin changes were given to nursing assistants.

Throughout November and into December R3's skin conditions worsened. There were additional open areas on her buttocks and doctor's orders were revised to address skin breakdown caused by excessive moisture due to R3's incontinence and a rash that had developed.

During survey it was observed that R3's plan of care was not being followed. The facility was unable to provide documentation indicating that R3 received any treatment for her wounds from December 30, 2016 through January 3, 2017. During this same time period R3's weekly skin assessments were inconsistent with the number of open areas varying from one to four and do not provide evidence that staff performed complete and methodical assessments. Moreover, the facility was unable to provide surveyors any additional assessment information when asked for this on January 5, 2017 during the survey, nor was it able to provide its policy for pressure ulcer care.

The facility argued that R3 chose how she wanted to be cared for and that self-determination is a fundamental right of each resident under its care, and despite cognitive losses, each person can make choices that are part of their care. Further, facility staff felt they provided appropriate care for R3's pressure ulcers and that they were unavoidable as R3 did not wish to comply with ongoing treatments and that because of her medical condition the pressure ulcers were unavoidable.

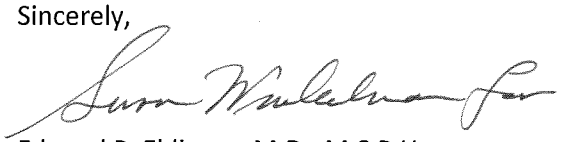
The State Operations Manual (SOM) for surveyors, also available to facility staff, states with respect to pressure ulcers "avoidable" means that the resident developed a pressure ulcer and that he facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with the resident's needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or

revise the interventions as appropriate. The SOM goes on to state "unavoidable" means that that resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

The facility is to provide cares and services to promote the prevention of pressure ulcer development and promote the healing of pressure ulcers that are present. Harm is avoidable only if the facility has done everything in the definition of "avoidable." The interventions that were eventually developed to ensure maximum pressure reduction for R3 were not properly implemented and re-evaluated. Although documentation submitted indicates R3 refused to be repositioned at times, caregivers also noted success in repositioning R3. There is no documentation of R3's caregivers consulting over R3's repositioning refusals and considering alternative approaches to increase her compliance with repositioning. Observations on survey verify lack of cares being provided to R3 and were not refuted by the facility. This deficiency is a valid deficiency, Level G, actual harm, isolated.

This concludes the IIDR process. As noted in the Department of Health's Information Bulletin 04-07, the final decision of the Department of Health is not binding on the Centers for Medicare and Medicaid Services.

Sincerely,



Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975
www.health.state.mn.us

cc: Judge Oxley
Tamika Brown, CMS Region V
Cheryl Hennen
Susan Winkelmann
Holly Kranz
Cynthia Olson

MINNESOTA
OFFICE OF
ADMINISTRATIVE
HEARINGS

PO Box 64620
Saint Paul, MN 55164-0620
mn.gov/oah

PH (651) 361-7900
TTY (651) 361-7878
FAX (651) 539-0310

April 24, 2017

VIA E-FILING ONLY
Edward Ehlinger
Commissioner
Minnesota Department of Health
ATTN: Mary Cahill - HPICM
PO Box 64900
St. Paul, MN 55164-0900
mary.cahill@state.mn.us

Re: ***In the Matter of Ostrander Care and Rehab (IIDR)***
OAH 19-0900-34218

Dear Commissioner Ehlinger:

Enclosed and served upon you is the Administrative Law Judge's **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** in the above-entitled matter. The official record, along with a copy of the recording of the hearing, is also enclosed. The Office of Administrative Hearings' file in this matter is now closed.

If you have any questions, please contact my legal assistant Kendra McCausland at (651) 361-7870 or kendra.mccausland@state.mn.us, or facsimile at (651) 539-0310.

Sincerely,

JEFFERY OXLEY
Administrative Law Judge

JO:klm
Enclosure
cc: Marian Rauk
Holly Kranz

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
PO BOX 64620
600 NORTH ROBERT STREET
ST. PAUL, MN 55164-0620

CERTIFICATE OF SERVICE

In the Matter of Ostrander Care and Rehab (IIDR)	OAH Docket No.: 19-0900-34218

Kendra McCausland certifies that on April 24, 2017, she served the true and correct **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDATION** by courier service, by placing it in the United States mail with postage prepaid, or by electronic mail, as indicated below, addressed to the following individuals:

VIA E-FILING ONLY
Edward Ehlinger
Commissioner
Minnesota Department of Health
ATTN: Mary Cahill - HPICM
PO Box 64900
St. Paul, MN 55164-0900
mary.cahill@state.mn.us

VIA EMAIL ONLY
Holly Kranz
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza Ste 2105
Mankato, MN 56001
holly.kranz@state.mn.us

Marian Rauk
Ostrander Care and Rehab
305 Minnesota St
Ostrander, MN 55961

THIS DOCUMENT CONTAINS NOT PUBLIC DATA

OAH 19-0900-34218

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Ostrander Care and Rehab (IIDR)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDATION

The above matter is the subject of an independent informal dispute resolution (IIDR) proceeding before Administrative Law Judge Jeffery Oxley. Ostrander Care & Rehab (the Facility) requested that the recommended decision be based on written submissions in lieu of a meeting.

The parties agreed to a schedule for the submission of written materials. The parties had until April 10, 2017, to submit materials and both parties did so.[1] The Facility submitted a statement accompanied by Addendums 1 through 6 and Exhibits 1 through 5. The Department submitted a statement and Exhibits A through I. The record closed on April 10, 2017.

Holly Kranz, RN, PHN, LNHA, and Health Facility Evaluator II, appeared on behalf of the Minnesota Department of Health (Department). Marian Rauk, Administrator, appeared on behalf of the Facility.

DISPUTED DEFICIENCY CITATION (TAG)

The following deficiency citation was submitted to the Administrative Law Judge for consideration in this matter.

Tag F314, scope and severity level G.

RECOMMENDATION

The Administrative Law Judge respectfully recommends that the Commissioner **AFFIRM** the finding of deficiency F314 with scope and severity level G.

[1] Letter dated February 23, 2017 to Mary Cahill, Minnesota Department of Health and Marian Rauk, Ostrander Care & Rehab.

FINDINGS OF FACT

Regulatory Background

1. The Social Security Act mandates the establishment of minimum health and safety standards that must be met by providers and suppliers participating in the Medicare and Medicaid Programs.[2] Participation requirements for skilled nursing and long-term care facilities are set forth in 42 C.F.R. § 483, subp. B (2016).

2. The Centers for Medicare and Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid.[3]

3. CMS assures compliance with the participation requirements through surveys conducted by state agencies, which have been delegated the responsibility for such action.[4] In Minnesota, the state survey agency is the Department. The state survey agency reports any deficiencies to the CMS on a standard form called a Statement of Deficiencies.[5]

4. A deficiency is a failure to meet a participation requirement set forth in 42 C.F.R. § 483.[6] Deficiencies are cited as alpha-numeric tags, which correspond to a regulatory requirement in 42 C.F.R. § 483.[7] The citations are commonly referred to as F-Tags because they relate to the survey enforcement provisions set forth in 42 C.F.R. § 488, subp. F (2016).

5. To assist state agencies in conducting surveys, CMS publishes a State Operations Manual (SOM).[8] The SOM provides guidance to state survey agencies, as well as regulated facilities, as to how the CMS interprets the various rules and regulations.[9]

6. When a violation of a rule or a deficiency is identified, the state survey agency must then make a determination as to the seriousness of that deficiency.[10] The seriousness of the deficiency determines the remedy or the sanction imposed.[11] The seriousness of the deficiency depends upon its scope and its severity.[12]

---

[2] 42 U.S.C. §§ 1302, 1395hh (2012). *See also* 42 C.F.R. § 483 (2016).
[3] Department Statement at 2.
[4] *See, e.g.,* 42 U.S.C. § 1864(a) (2012); 42 C.F.R. § 488.11 (2016).
[5] *See, e.g.,* Ex. C.
[6] 42 C.F.R. § 488.301 (2016).
[7] *See* Ex. C.
[8] *See* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html.
[9] Department Statement at 2.
[10] 42 C.F.R. § 488.404 (2016).
[11] *Id.*
[12] *Id.*

7. Guidance on scope and severity is set forth in the SOM at Appendix P, Deficiency Categorization.[13] Pursuant to 42 U.S.C. § 488.404 and the SOM, there are four levels of severity: Level 1 through Level 4, with Level 1 being the lowest level of severity and Level 4 the highest.[14]

8. A Level 1 deficiency involves no actual harm to any resident in the care of a facility but has the potential to cause minimal harm. A Level 2 deficiency involves no actual harm to any resident, but has the potential to cause more than minimal harm but does not indicate a situation of immediate jeopardy.[15] A Level 3 deficiency involves actual harm but does not pose an immediate jeopardy.[16] A Level 4 deficiency involves an immediate jeopardy to a resident's health or safety.[17]

9. Scope has three levels: isolated, pattern, and widespread.[18]

10. Scope and severity are represented by a Scope and Severity Grid in the SOM (Grid).[19] The Grid is a three-column, four-row grid table with the scope indicated by the column and the severity by the row.[20] The left-most column is for deficiencies that are isolated while the right-most indicates a widespread deficiency and the middle column indicates the deficiency is observed in a pattern.[21] The bottom-most row of the Grid indicates a Level 1 or least severe deficiency, and the severity of a deficiency increases through Level 4, the top row of the Grid.[22]

11. Each cell of the Grid is given a letter, starting at the bottom left-most corner of the Grid with "A," and continuing across the row with the next cells being labelled "B," and "C." The second row of the Grid is assigned "D," "E," and "F"; the third row: "G," "H," and "I;" and the fourth row: "J," "K," and "L." Thus "A" represents an isolated deficiency that did not cause any actual harm and has a potential to cause only minimal harm while an "L" indicates a deficiency that is widespread and poses an immediate jeopardy to a resident's safety or health.[23] Levels F through L are considered to represent a substandard quality of care.[24] Below is a copy of the Grid.[25]

---

[13] *Id.*
[14] *Id*; SOM Appendix P.
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] Ex. C.
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*

Substandard quality of care in any deficiency in 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 constitutes immediate jeopardy to resident health or safety; or, a pattern of or widespread actual harm that is not immediate jeopardy; or, a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Substantial compliance

	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	K PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	L PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2
Actual harm that is not immediate jeopardy	G PoC Required* Cat. 2 Optional: Cat. 1	H PoC Required* Cat. 2 Optional: Cat. 1	I PoC Required* Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required* Cat. 1 Optional: Cat. 2	E PoC Required* Cat. 1 Optional: Cat. 2	F PoC Required* Cat. 2 Optional: Cat. 1
No actual harm with potential for minimal harm	A No PoC No Remedies Commitment to Correct Not on HCFA-2567	B PoC	C PoC

Substandard quality of care in any deficiency in 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 constitutes immediate jeopardy to resident health or safety; or, a pattern of or widespread actual harm that is not immediate jeopardy; or, a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Substantial compliance

Deficiency F314

12. Ostrander Care and Rehab is a long-term care facility in Ostrander, Minnesota, that provides skilled nursing to its residents as well as other services.

13. This matter arises from a survey conducted by Jennifer Kolsrud-Brown, RN, HFE II (the Surveyor). The survey was exited on January 6, 2017.[26]

14. The survey resulted in the issuance of a Statement of Deficiencies on February 2, 2017, that cited several deficiencies, among them deficiency F314 with respect to resident R3.[27] The Facility disputes only deficiency F314 and sought an independent review through the IIDR process.

15. Tag F314 is based on 42 C.F.R. § 483.25(b)(1) (2016) and concerns the prevention and treatment of pressure ulcers. A pressure ulcer "is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s)."[28] This regulation provides the following standards for care to prevent and treat pressure ulcers:

> (b) Skin Integrity
>
> (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that:
>
> (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
>
> (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

16. The federal guidelines for pressure ulcers distinguish between avoidable and unavoidable pressure ulcers. The guidelines provide the following definitions:

> "Avoidable" means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluation the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of intervention; or revise the interventions as appropriate.[29]
>
> "Unavoidable" means that the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors' defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of

[26] Ex. I.
[27] Ex. E.
[28] Ex. F.
[29] Ex. F at 2.

practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.[30]

17. Federal authorities give the following guidance to long-term care facilities with respect to pressure ulcers:

> The facility should have a system/procedure to assure: assessments are timely and appropriate; interventions are implemented, monitored, and revised as appropriate; and changes in condition are recognized, evaluated, reported to the practitioner, and addressed.[31]

18. If pressure ulcers are not healing properly, federal guidance indicates a resident's caregivers must reconsider treatments and interventions:

> The complexity of the resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment (for example, why some, or all, of the plan's interventions remain relevant despite little or no apparent healing).[32]

19. The Department determined that the Facility failed to assess and provide appropriate care to R3, who developed pressure ulcers following her admission.[33] With respect to R3's care, the Department found that the Facility "failed to provide skin care in accordance with physician orders, to promote healing and prevent further pressure ulcers from developing...."[34] According to the Department, R3 sustained harm as a result.[35]

The Facility's Care for R3's Wounds

20. R3 was born in 1922 and, at age 92, was admitted to the Facility on September 12, 2014.[36] R3 was diagnosed as suffering from a major depressive disorder, primary hypertension, and "unspecified dementia without behavioral disturbance (Profound Dementia)" at the time of her admission.[37]

21. The Facility provided R3 with a pressure reduction mattress on admission. R3's caregivers used pillows to position R3 when she "was cooperative with position schedule and devices."[38]

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[30] Ex. F at 2.
[31] Ex. F at 5.
[32] Ex. F at 19.
[33] Department Statement at 4.
[34] *Id.*
[35] Department Statement at 9-10.
[36] Ex. G at 2; Facility Statement at 2.
[37] Ex. G at 4.
[38] Facility Statement at 2.

22. R3's Care Plan in September 2015 indicated she was to receive extensive assistance with repositioning and toileting.[39]

23. Beginning in September 2015 and continuing thereafter, R3's Care Plan noted she was incontinent.[40]

24. Both urine and feces may irritate skin. Prolonged exposure to either may hasten skin breakdown and render skin more susceptible to injury.[41]

25. On October 31, 2016, the Facility asked Dr. Lindy Hankel to see R3 due to her decline in status.[42] Dr. Hankel's report noted that R3 suffered from an anxiety disorder but did not note any open areas or pressure ulcers.[43]

26. On November 9, 2016, the Facility requested that Dr. Hankel visit R3 again due to "ongoing issues related to behavior. She has advanced dementia and over the past several weeks she has gotten much more agitated. She will yell out help. She cannot be redirected."[44] Dr. Hankel determined that R3 should be evaluated by hospice.[45]

27. On November 11, 2016, R3 was admitted to hospice care.[46]

28. Dr. Hankel saw R3 again on November 16, 2016, and noted R3's generalized anxiety disorder but did not note any problems with pressure ulcers.[47]

29. On November 17, 2016, the Facility initiated weekly assessments of R3's pressure ulcer. That day a caregiver noted R3's condition:

> buttocks are red with small open areas on left side buttock, washed gently and barrier applied. Left inc[ontinence] pad off at night to get air to areas. Skin is otherwise intact. She refused to lay on her side, we did manage to get the pillow under her some to offload pressure from her butt skin intact.[48]

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[39] Ex. G at 5.
[40] Ex. G at 7-8.
[41] Ex. F at 11.
[42] Ex. 1.
[43] *Id.*
[44] Ex. 2.
[45] *Id.* The Facility asserts that on November 10, Dr. Hankel was informed of a change in R3's condition by a nurse. Facility Statement at 3. The Facility does explain what changed in R3's condition.
[46] Facility Statement at 3 and Addendum 2.
[47] Ex. 3.
[48] Ostrander Statement at Addendum 1.

30. R3's CNA Assignment Card identifies both pressure ulcers and incontinence as problems for nurse aides to treat. For pressure ulcers, nurse aides are to:

> Assist with hygiene and general skin care. Avoid using hot water for cleansing. Minimize pressure on bony prominences. Offer fluids with position changes. Report changes to nurse. Use moisturizer with cares. Keep skin clean and dry. Use incontinence pads. Barrier cream to peri area as needed. Keep linen clean, dry, and wrinkle free.[49]

For incontinence, the instructions for nurse aides include:

> Cleanse peri-area and apply barrier cream to after incontinent episodes...Resident is to be toileted every 2-3 hours and upon request. Her incontinence product needs to be changed during toileting if wet or soiled...Brief used for incontinence. Check and change every two hours. Peri care if incontinence has occurred. Report any changes in skin condition to charge nurse.[50]

31. R3's caregivers observed that on November 21, 2016, R3 was suffering from two wounds, one on her sacrum (Wound 1) and another on her left lower buttock (Wound 2).[51]

32. On November 22, 2016, R3's Care Plan was changed to End of Life Care as R3 had been admitted to hospice care.[52] R3's caregivers were instructed to assess whether R3 was in pain and to administer morphine "as needed for moderate to severe acute pain."[53] In addition, caregivers were to "reposition for comfort."[54]

33. Also on November 22, R3's Care Plan noted that R3 was experiencing mixed incontinence and "[t]otal loss of bowel and bladder control."[55] The Care Plan further instructed nurses to "[a]pply barrier cream to buttocks to prevent skin irritation."[56] Nurses were to provide "barrier ointments," to "[c]heck and change every 2 hours," and to "[m]onitor skin condition."[57] The Care Plan gave the following instructions to nurses aides:

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[49] Ex. G at 16.
[50] *Id.*
[51] Ex. G at 23-24.
[52] Ex. G at 10.
[53] Ex. G at 10.
[54] *Id.*
[55] Ex. G at 13.
[56] *Id.* at 10.
[57] *Id.* at 13.

Brief used for incontinence. Check and change every 2 hours. Peri care if incontinence has occurred. Report any changes in skin condition to charge nurse. Apply barrier cream.[58]

34. Dr. Hankel visited R3 again on November 23, 2016. Dr. Hankel observed that R3 "has developed a rash on her perineum and buttocks. This has been worse over the last week. They have been using barrier cream with antifungal medication….. ."[59] Dr. Hankel noted a "marked fungal infection with some peeling in the gluteal folds and on her buttocks."

35. R3's Care Plan notes on November 25, 2016, the goal of providing "skin treatment to improve breakdown areas."[60]

36. On November 26, 2016, one of R3's caregivers wrote "skin issues noted buttock area with three open areas around coccyx area." The caregiver noted that R3 "was positioned on her back with a pillow under hip to keep pressure off coccyx area."[61]

37. A caregiver who conducted R3's weekly skin assessment on December 1, 2016, noted: "Buttocks red and skin is thin. Small open areas on L. butt (Wounds 2 and 3). Refuses to offload."[62]

38. Federal guidance states that "[a]n new pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers."[63]

39. A hospice nurse wrote on December 2, 2016, that adhesive optifoam be applied to R3's coccyx and changed every three days and if the dressing became soiled.[64]

40. On December 5, 2016, four open areas were observed: left lower buttock (Wound 2), left mid buttock (Wound 3), right mid buttock (Wound 1), and right lower buttock (Wound 4).[65] Treatment for R3's skin noted that R3 "receives turning/repositioning program."[66]

41. Following R3's next weekly skin assessment, which was conducted ten days later on December 15, 2016, a caregiver noted that that R3 "[c]ontinues to have

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[58] *Id.* at 13.
[59] *Id.* at 22.
[60] *Id.* at 12.
[61] Addendum 1.
[62] *Id.*
[63] Ex. F at 15.
[64] *Id.* at Addendum 3. The Administrative Law Judge made his best guess of the scrawled handwriting.
[65] Ex. G at 27. It is not entirely clear whether these open areas on R3's right side are in addition to the sacrum wound (Wound 1) because the sacrum is centrally located and higher than mid buttock On January 4, 2017, the Surveyor observes four wounds. One is described as appearing on R3's coccyx and a second is identified as appearing on her lower coccyx. Ex. E. 18. Because four wounds are mentioned in both parties' submissions, the Administrative Law Judge concludes that the wounds on the right mid buttock and lower buttock are the coccyx and lower coccyx wounds.
[66] Addendum 1.

area on L. buttock covered. Small open area. Res. Skin is thin and fragile. Res refuses to turn side to side."[67]

42. R3's December 15, 2016, skin assessment failed to note whether the multiple open areas observed on December 5 had healed or remained open. No measurement of the open area was reported.

43. On December 21, 2016, Dr. Hankel provided directions for care of two wounds incurred by R3 and certified an order for materials to dress and treat them. She also provided a plan of care for R3's two wounds. Doctor Hankel diagnosed Wound 1 on R3's sacrum as a pressure ulcer but diagnosed Wound 2 on R3's left lower buttock as a non-pressure ulcer caused by the skin being subject to excessive moisture due to R3's incontinence.[68] Dr. Hankel prescribed the use of collagen, alginate, foam, and adhesive composite "to cover and protect for frequent episodes of Incontinence. BID [indicating twice day] change due to frequent loose stool and urinary incontinent."[69] For treatment and intervention, Dr. Hankel advised caregivers to "[c]leanse wound and periwound tissue. Pat dry. Apply barrier past to wound edges. Apply silver collagen to wound bed. Apply silver alginate to wound bed. Apply adhesive foam x 12 days, when foam runs out use adhesive composite dressing. Change BID."[70] Dr. Hankel measured the two wounds.[71] Dr. Hankel does not mention Wounds 3 and 4.

44. After R3's weekly skin assessment on December 22, 2016, a caregiver noted "no problems noted skin intact skin issues noted within normal limits."[72] No measurements of R3's wounds were reported.

45. Four days later on December 26, 2016, a caregiver noted "[a]rea still open. Very fragile. Res was turned and off loaded."[73]

46. Following R3's weekly skin assessment on December 29, 2016, a caregiver noted two areas with ulcers on R3's posterior. Area 1 consisted of a 2 by 2 centimeter wound on R3's sacrum. Area 2 involved R3's left lower buttock, which had a 1 by 1.5 centimeter wound.[74] No mention of Wound 3 or 4 was made.

47. The Facility provided no documentation indicating that R3 received any treatment for her wounds from December 30, 2016 through January 3, 2017.[75]

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[67] *Id.*
[68] Ex. G at 23-24.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] Addendum 1.
[73] *Id.*
[74] *Id.*
[75] *Id.* at 34-39.

48. The Facility's Toileting and Repositioning Worksheet as well as its CNA Assignment Card state that R3 was to be repositioned and checked for incontinence every two hours.[76]

49. The Surveyor interviewed several of the Facility's staff members. The nurse responsible for R3's dressing changes on January 3, 2017 did not change R3's dressing and said that she thought that R3's dressings were to be changed every other day rather than twice a day.[77] Another nurse stated that she had changed R3's dressings on the morning shift of January 2, 2017 and 3, 2017, but did not record doing so.[78]

50. R3's dressings were not changed on December 30 and 31, 2016, nor on January 1, 2017. R3's dressing were only changed once on January 2, 2017 and 3, 2017.

51. On January 4, 2017, the Surveyor observed R3 for over two hours, during which time Facility staff did not reposition her. Informed that R3 had been put to bed at 8:00 a.m., the Surveyor observed Facility staff repositioning R3 and checking her for incontinence at 10:37 a.m. The primary Surveyor observed at that time that R3's coccyx dressing was soiled with what appeared to be feces and that gel was leaking through a tear in the dressing. R3's dressing had not been recently changed. R3's caregivers began to put a new incontinent brief on over the soiled dressing when the Surveyor intervened and asked the caregivers what they were supposed to do when a dressing was soiled. At that point, the caregivers determined to consult a nurse.[79]

52. On January 4, 2017, a caregiver noted that R3 complained about a "burning" sensation as her area 2 wound was dressed. The nurse removed the dressing, cleansed the area, and contacted the wound nurse. Also, R3 was visited by a hospice nurse that day, who remarked that R3 complained of a high level of pain and was incontinent. The hospice nurse changed R3's incontinence pad and provided peri-care.[80]

53. Dr. Hankel visited R3 on January 4, 2017. Dr. Hankel noted that R3 "is being treated for excoriation on her buttocks which is being treated by nursing."[81]

54. On January 5, 2017, the Surveyor inquired of Facility staff as to what additional assessment had been made with regard to the development of Wounds 2, 3 and 4. Facility staff did not provide any additional assessment information.[82] The

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[76] Ex. G at 16-17.
[77] Ex. H.
[78] *Id.*
[79] Ex. E at 17-18.
[80] *Id.*; Addendums 6.
[81] Ex. 5
[82] *Id.* at 19.

Surveyor also asked for the Facility's policy for pressure ulcer care but did not receive it.[83]

55. R3's weekly skin assessments from December 5, 2016 to January 4, 2016, were inconsistent. The number of open areas vary from one to four. The weekly reports do not evidence that Facility staff performed complete and methodical assessments.

Issuance of Statement of Deficiency

56. Based upon its investigation and review of the Facility's policies, the Department concluded that the Facility violated 42 C.F.R. 483.25(b)(1) (Pressure ulcers).[84] The Department determined that the Facility failed:

> to provide skin care in accordance with physician orders, to promote healing and prevent further pressure ulcers from developing for 1 of 2 residents (R3) reviewed for pressure ulcers. As a result of the facility's failure to assess and to provide care, R3 sustained harm when she developed additional pressure ulcers.

57. The Department determined that the scope of the deficiency was isolated and while there was actual harm to a resident, there was no immediate jeopardy. Accordingly, the Department used the Grid to assign the deficiency a seriousness level of G.[85]

58. The Department proposed a plan of correction as follows:

> The DON[86]/Designee will complete audits weekly for one month, monthly for three months, and quarterly for one year. Findings will be shared with the Quality Assurance & Assessment Committee.[87]

59. The Facility timely filed a request for an IIDR proceeding pursuant to Minn. Stat. § 144A.10, subd. 16 (2016).

Based on these Findings of Fact, the Administrative Law Judge makes the following:

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[83] *Id.*
[84] Department Statement at 4 (citing 42 C.F.R. § 483.25(c), Pressure Sores, but in the current Code of Federal Regulations, "pressure ulcers" are under section 483.25(b)(1)).
[85] *Id.* at 3.
[86] "DON" is an acronym for "Director of Nursing."
[87] Ex. E at 15.

CONCLUSIONS OF LAW

1. The Commissioner of the Department of Health (Commissioner) and the Administrative Law Judge have jurisdiction in this matter, pursuant to Minn. Stat. §§ 14.57, 144A.10 (2016).

2. The Administrative Law Judge must issue one or more of the following findings with regard to the deficiency in dispute:

(1) Supported in full. No deletion of Department findings and no change in the scope or severity assigned to the deficiency citation;

(2) Supported in substance. The citation is supported, but one or more findings are deleted without any change in the scope or severity assigned to the deficiency;

(3) Deficient practice cited under wrong requirement of participation. The citation is amended by moving it to the correct requirement of participation;

(4) Scope not supported. The citation is amended through a change in the scope assigned to the citation;

(5) Severity not supported. The citation is amended through a change in the severity assigned to the citation; or

(6) No deficient practice. The citation is deleted because the findings did not support the citation or the negative resident outcome was unavoidable. The findings of the arbitrator are not binding on the commissioner.[88]

3. If a deficiency poses not greater risk to a resident's health or safety than the potential for causing minimal harm, the facility is in substantial compliance.[89]

4. 42 C.F.R. § 483.25(c)(1), (2) (2016) require a facility to ensure that "a resident who enters the facility without pressure sores does not develop" pressure sores unless they were unavoidable due to the resident's clinical condition. The regulation also requires that a resident who has pressure sores "receives necessary treatment and services to promote healing...."[90]

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[88] Minn. Stat. § 144A.10, subd. 16(d).
[89] 42 C.F.R. § 488.303 (2016).
[90] 42 C.F.R. § 483.25(c)(1), (2); Ex. 6 at 1.

5. Ostrander Care & Rehab provides long-term care and skilled nursing and is accordingly subject to the federal Social Security Act and 42 C.F.R. Parts 483 and 488 (2016).

6. All long-term care and skilled nursing home facilities regulated under the Social Security Act must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents.[91]

7. A regulated facility must also promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.[92]

8. Residents of regulated facilities "have the right to participate in the development and implementation of his or her person-centered plan of care,"[93] including the right to participate in the care planning process, [and]...the type, amount, frequency, and duration of care."[94]

9. R3 suffered actual harm from the Facility's failure to provide necessary treatment and services to promote the healing of her ulcers and to prevent new ulcers from developing.

10. The scope of the deficiency is isolated because only R3 suffered actual harm.

11. Tag F314 was properly assigned level F314 for Wounds 1 and 3.

12. Tag F314 may have been not properly assigned with respect to Wounds 2 and 4. These wounds originated due to R3's incontinence but may have worsened due to being subjected to unrelieved pressure. The record does not indicate the appropriate tag for ulcers which originated due to incontinence.

Based upon these Conclusions of Law, and for the reasons explained in the accompanying Memorandum, the Administrative Law Judge makes the following:

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[91] 42 C.F.R. § 483.13(c).
[92] 42 C.F.R. § 483.15(a).
[93] Facility Statement at 2.
[94] *Id.* at 2, citing 42 C.F.R. § 483.10 and the Federal 1987 Nursing Home Reform Law which "places a strong emphasis on individual dignity, choice and self-determination. Each resident has the right to independent choices." *Id.* at 2.

RECOMMENDATION

The Administrative Law Judge respectfully recommends that the Commissioner **AFFIRM** Tag F314 at severity G.

Dated: April 24, 2017

JEFFERY OXLEY
Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6), this recommended decision is not binding upon the Commissioner. Pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative law Judge within ten calendar days of receipt of this recommended decision.

MEMORANDUM

General Regulatory Background

Skilled nursing facilities participating in the Medicare program must meet certain requirements, which are set forth in 42 C.F.R. § 483, subp. B. Compliance with these requirements is determined through regular surveys (inspections)[95] conducted by state agencies, such as the Department, under agreement with the federal Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS), pursuant to 42 C.F.R. § 488. The state agency conducting the survey reports any compliance deficiencies (citations or tags) to CMS on a standard form called a Statement of Deficiencies.[96]

The standards by which the state agency determines compliance are found at 42 C.F.R. § 488.26:

> (b) The decision as to whether there is compliance with a particular requirement, condition of participation, or condition for coverage depends upon the manner and degree to which the provider or

[95] Minn. Stat. § 144A.10, subd. 2.
[96] *See, e.g.,* Ex. E.

supplier satisfies the various standards within each condition. Evaluation of a provider's or supplier's performance against these standards enables the state survey agency to document the nature and extent of deficiencies, if any, with respect to a particular function, and to assess the need for improvement in relation to the prescribed conditions.

(c) The state survey agency must adhere to the following principles in determining compliance with participation requirements:

(1) The survey process is the means to assess compliance with federal health, safety and quality standards;

(2) The survey process uses resident and patient outcomes as the primary means to establish the compliance process of facilities and agencies. Specifically, Surveyors will directly observe the actual provision of care and services to residents and/or patients, and the effects of that care, to assess whether the care provided meets the needs of individual residents and/or patients;

(3) Surveyors are professionals who use their judgment, in concert with Federal forms and procedures, to determine compliance;

(4) Federal procedures are used by all Surveyors to ensure uniform and consistent application and interpretation of federal requirements;

(5) Federal forms are used by all Surveyors to ensure proper recording of findings and to document the basis for the findings.

(d) The state survey agency must use the survey methods, procedures, and forms that are prescribed by CMS.

(e) The state survey agency must ensure that a facility's or agency's actual provision of care and services to residents and patients and the effects of that care on such residents and patients are assessed in a systematic manner.

In addition to the language of the regulations, the agency relies on the SOM. The SOM is a federal document that incorporates the federal regulations applicable to facilities enrolled in the Medicare and Medicaid programs, and provides guidelines for

the survey agency to follow when determining whether a facility meets the required standards.[97]

Survey of Ostrander Care & Rehab

The Department cited the Facility for noncompliance with 42 C.F.R. § 483.25(b). The regulation requires a facility to ensure that "a resident who enters the facility without pressure sores does not develop" pressure sores unless they were unavoidable due to the resident's clinical condition. The regulation also requires that a resident who has pressure sores "receives necessary treatment and services to promote healing...."[98]

The Surveyor determined that the Facility failed to prevent the development and worsening of four unstageable pressure ulcers. Moreover, the Surveyor determined the Facility failed to treat them appropriately, resulting in actual harm to R3.[99] The deficiency tag was set at a scope and severity level of G, because the pressure ulcers were an isolated incident that involved actual harm to a single resident but did not constitute an immediate jeopardy.[100]

According to Dr. Hankel's diagnosis, R3's wounds did not all originate from unrelieved pressure. The Department identified four wounds. Dr. Hankel diagnosed the etiology of Wounds 1 and 2. She identified Wound 1 on R3's sacrum[101] as a pressure ulcer, and Wound 2 on R3's lower left buttock as a "non-pressure" ulcer caused by moisture resulting from R3's incontinence degrading her skin.

The record does not provide any authoritative etiology of Wounds 3 and 4. The Department assumes all four of R3's wounds were pressure ulcers. This conclusion is apparently contradicted by Dr. Hankel's diagnosis of Wound 2.

Wound 3 was located on R3's coccyx, below Wound 1. Its location suggests that, like Wound 1, Wound 3 was a pressure ulcer, and the Administrative Law Judge so concludes.

Because Wound 4 was located close to Wound 2, it seems likely that Wound 4 originated due to R3's incontinence. The Administrative Law Judge concludes that R3 suffered from two pressure ulcers and two wounds caused by her incontinence. Wounds 2 and 4 may have originated from incontinence but worsened due to unrelieved pressure. The record does not provide a basis for the Administrative Law Judge to make this determination.

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[97] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html
[98] 42 C.F.R. § 483.25(c)(1), (2); Ex. 6 at 1.
[99] Department Statement at 7-9.
[100] Ex. 3.
[101] Wound 2 was also described as located on R3's coccyx with another wound on R3's lower coccyx. Ex. E at 18.

The development of additional ulcers indicates a deficiency in care, but on the record provided him, the Administrative Law Judge cannot determine if Tag F314 is appropriate for all four wounds. The record does not indicate whether Wounds 2 and 4 worsened due to unrelieved pressure or because of R3's continuing incontinence and the Facility's failure to properly treat her incontinence. If the latter, another tag is likely appropriate for these wounds. In any event, the record is clear that R3 suffered from one or more pressure ulcers that developed after she was admitted to the Facility.

The Facility does not challenge the Department's identification of all wounds on R3's posterior as pressure ulcers. The Facility also admits that it "did not provide extensive documentation of the issue listed as 'pressure area,'" but contends that the wounds were "unavoidable." The Facility argues that:

> [o]ur resident chose how she wanted to be cared for and that is appropriate for every resident under our care. Self-determination is a fundamental right of each resident under our care and, despite cognitive losses, each person can make choices that are part of their care.[102]

The staff of the Facility "feel[s] strongly that we did provide care that would prevent pressure ulcer development but pressure ulcer development was unavoidable."[103] The Facility explains that:

> R3 did not wish to comply with ongoing treatment options throughout her declining health. Our focus for R3 throughout our long standing relationship with her was to provide a quality of life that she was entitled to. Staff honored her wishes and provided her a comfortable and pain free end of life process. R3 chose how she wanted her life to be lived.[104]

The Facility cites to a National Pressure Ulcer Advisory Panel conference held in 2010.[105] The Facility summarized the Panel's findings thusly:

> The panelists unanimously voted that not all pressure ulcers are avoidable because there are patient situations where pressure cannot be relieved and perfusion cannot be improved. Due to physical condition, illness, psychological issues, and at times social-cultural aspects, terminally ill individuals are at increased risk of pressure ulcer development. The panelists recognized that no formal diagnostic criteria exist for skin failure. They supported that skin failure is a documentable condition and that skin failure is not the same as pressure ulcer. The panel recognized the phenomenon skin failure despite scant mention in the literature. The

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[102] Facility Statement at 2. Following the quoted material, "Personal communication- Jan Garard" appears in parentheses. The Administrative Law Judge is unable to locate in the submitted materials from both parties any reference explaining who Jan Garard is, but presumes it refers to a person on the Facility's staff.

[103] *Id.*

[104] *Id.*

[105] *Id.*

> panel was unanimous that pressure ulcers were not the same as skin failure. The panelists reached consensus that unavoidable pressure ulcers may develop in patients who are hemodynamically unstable, terminally ill, have certain medical devices in place, and are nonadherent with artificial nutrition or repositioning.[106]

Although the Administrative Law Judge has no reason to doubt the existence of unavoidable pressure ulcers, the Facility did not present evidence from a medical professional stating that R3's pressure ulcers (Wounds 1 and 3) were unavoidable. The record does establish that R3 resisted repositioning on occasion, that R3 had an anxiety disorder, and could be difficult to understand. However, the record also shows that R3 could be successfully repositioned at times, perhaps when medication was controlling her anxiety.

The Facility's argument that R3 chose to be nonadherent with her treatment when she suffered from advanced dementia is troubling. The Facility cites a bioethicist's opinion that patients should be entitled to refuse treatment for bedsores.[107] It is not clear that the bioethicist's opinion applies to patients with advanced dementia. The record provides no guidance on the extent to which a person with advanced dementia can be said to have chosen to refuse treatment. However, federal guidance for treating pressure ulcers includes the following direction:

> The facility should have a system/procedure to assure: assessments are timely and appropriate; interventions are implemented, monitored, and revised as appropriate; and changes in condition are recognized, evaluated, reported to the practitioner, and addressed.[108]

Federal guidance directs facilities to arrange for the coordination of assessments, interventions, and monitoring. If monitoring indicates that a pressure ulcer is not healing, the Facility must have procedures in place for reconsidering treatment options and documenting the rationale for continuing or altering the present treatment. Guidance indicates that Facility staff should have documented R3's resistance to repositioning and:

> The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment (for example, why some, or all, of the plan's interventions remain relevant despite little or no apparent healing).[109]

The Facility did not submit documentation of R3's caregivers implementing the interventions on December 30 or 31, 2016, or January 1 through 5, 2017. Although the documents submitted indicate that R3 refused to be repositioned at times, caregivers also noted their success in repositioning R3. There is no documentation of R3's

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[106] *Id.* at 2-3.
[107] Facility Statement at 2 (citing "You MUST Let My Bedsores Kill Me," Art Caplan)
[108] Ex. F at 5.
[109] Ex. F at 19.

caregivers consulting over R3's repositioning refusals and considering alternative approaches to her to increase her compliance with repositioning.

Nor did the Facility rebut the observations of the Surveyor of R3's substandard care on the morning of January 4, 2017. The Surveyor documented the Facility staff's failure to reposition R3 and check for incontinence every 2 hours. Further, the Surveyor had to intervene to prevent nursing aides from placing an incontinence brief over a torn dressing soiled by fecal matter.

Because the Facility did not document R3's caregivers consulting over her resistance to repositioning, failed to implement treatment procedures on several days, failed to document the treatment provided for R3's wounds on several days, and failed to rebut the care plan violations observed by the Surveyor, the Administrative Law Judge recommends that the Commissioner affirm the deficiency of F314 at severity G.

J. O.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M7TN

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 **01/06/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Vicky Hamersma, HFE NE II 02/02/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00040** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
January 23, 2017

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

RE: Project Number S5464028

Dear Ms. Rauk:

On January 6, 2017, a standard survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) with the remaining deficiencies is enclosed.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Public Safety verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on January 4, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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 electronic plan of correction should be directed to:

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

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

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

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

NO OPPORTUNITY TO CORRECT - REMEDIES

Centers for Medicare and Medicaid Services (CMS) policy requires that facilities will not be given an

opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 28, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiencies cited at K918 and F314. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their decision to impose remedies with appeal rights.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) 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. If you disagree with the findings 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.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 6, 2017 (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 6, 2017 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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 _____	01/06/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 280		2/15/17

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

Electronically Signed | 02/02/2017

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

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F 280	Continued From page 1 right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280		

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F 280	Continued From page 2 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise a care plan to include oral cares after all oral intake for 1 of 1 resident (R23) reviewed for activities of daily living and failed to revise care plan for 1 of 2 residents (R8) who had developed a heel wound and preventative cares and services had not been developed on care plan to promote healing and development of other wounds. Findings Include: R23's nursing assistant assignment guide undated, indicated extensive assist of 1 staff for oral cares, however did not direct staff on when the oral care should be completed. R23's care plan dated 12/4/15, indicted extensive assist of 1 for oral, however did not direct staff on when the oral care should be completed.	F 280	1. R23's care plan was updated to reflect the need for assistance for oral care after each meal. 2. Other residents who require assistance with ADLs care plans were reviewed, updated and revised as needed. 3. Care & Rehab Ostrander developed a policy for care plans to be updated with a significant change and on at least quarterly basis to assure that nursing assistants care sheets are up to date to provide care. 4. DON/Designee will audit this process on a weekly basis times one month, than monthly times three months and then quarterly for one year. Findings will be shared with Quality Assurance & Assessment Meeting.	

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F 280	Continued From page 3	F 280		

R23's annual Minimum Data Set (MDS) dated 12/6/16, identified required extensive assist of two for personal hygiene.

R23's Speech Therapist Progress & Discharge Summary dated 3/24/16, instructed staff, "Sit up during PO [oral] intake, check oral cavity post PO [oral] intake to ensure food has been swallowed completely or removed by staff assist to reduce risk of aspiration/penetration of oral stasis."

R23's Therapy/Nursing Communication form dated 3/24/16, instructed staff, "Continue oral cares after meals."

During a family interview on 1/3/16 at 6:27 p.m. family member (FM)-A was asked, "Does R23 get the help she needs getting dressed, toileting, or cleaning her teeth?" FM-A stated sometimes he comes in after lunch and R23 still had food in her mouth.

During a family interview on 01/05/17, at 1:41 p.m. FM-A stated he has found R23 to have food in her mouth after meals when he had come to visit on several occasions and stated other family members have noticed as well when they are at the facility visiting. FM-A stated there was even a sign on R23's dresser that directed staff to. "Please provide oral cares after all oral intake."

On 1/03/17, at 7:44:35 p.m. R23 was observed to be watching television in the main lobby and was chewing and moving an unidentifiable red item around her mouth. Surveyor asked R23 what she had in her mouth and R23 stated it was a piece of chicken. Surveyor alerted the administrator R23 had something in her mouth and the administrator put gloves on and removed the

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F 280	Continued From page 4	F 280		

item. The administrator stated she was unable to identify what it was. The licensed practical nurse (LPN)-A approached the administrator and surveyor and stated she thought it was a piece of fruit from the jello salad from supper

On 1/05/17, at 1:47 p.m. nursing assistant (NA)-A stated R23 was to have her teeth brushed in the morning and evenings.

On 1/05/17, at 1:48 p.m. nursing assistant (NA)-B stated she worked the evening shift and they brushed her teeth every night before she went to bed.

On 1/05/17, at 2:11 p.m. LPN-A stated she expected R23 to have oral cares completed after intake. LPN-A stated oral cares should have been completed on Tuesday evening after dinner. LPN-A stated R23 was found to have food in her mouth around 7:44 p.m. and the oral cares should have been completed by then. LPN-A stated the care plan and the nursing assistant assignment guide did not indicate oral care should be completed after all meals and stated it needed to be added to the care plans.

On 1/05/17, at 2:21 p.m. the administrator stated her expectation was oral care to be completed after meals if pocketing of food is occurring. The administrator stated the care plans for R23 needed to be revised to include oral cares after each meal to remove any debris left in the oral cavity.

Review of the policy Formulation of Resident Care Plans, with a revised date 7/2016, included, Guideline: Each resident will have a care plan present on his/her chart that provides information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 5	F 280		

for all members of the interdisciplinary care tea, regarding guidelines for individualized care. Procedure Guidelines: 5. An interdisciplinary care plan meeting will be held quarterly to review, revise, and update the plan of care. 6. Care plans will be reviewed by licensed staff quarterly.

R8's quarterly MDS dated 12/23/16 identified a stage II pressure ulcer.

R8's care plan dated 12/13/16 indicated a diagnosis of dementia and a decrease in activity of daily living participation, eating decline, on hospice, end of life cares. However, it did not contain any skin interventions to address current open vascular wounds located on left heel.

Doctor's visit notes dated 11/23/16 included R8 has a stage II left heel ulcer that is dry. Foot is warm and good capillary refill. She does not have any evidence of severe peripheral vascular disease (blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm.) left heel ulcer, improving, also indicated that wound care nurse is giving current wound care recommendations.

During an observation on 1/5/17, at 7:20 a.m., R8 was in bed lying on her back. Her heels were resting directly on the mattress and no heel protectors were noted. At 8:43 a.m., registered nurse (RN)-A was observed completing a dressing change to R8's left heel. RN-A described the wound as an open area. usually presents as a localized area of erythema or skin discoloration)

During an interview on 1/5/17, at 2:44 p.m., the facility administrator stated she would expect the

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F 280	Continued From page 6 MDS nurse to have developed skin interventions to promote healing of wound but also any of the nurses to update the care plan when the heel wound developed. The administrator verified R8's care plan did not include any interventions for prevention and/or healing of pressure ulcers.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 1 of 1 resident (R23) assessed to need assistance with nail care/grooming. Findings Include: R23's annual Minimum Data Set (MDS) dated 12/6/16, identified required extensive assist of two for personal hygiene. R23's nursing assistant assignment guide undated, indicated extensive assist of 1 staff for grooming. R23's care plan dated 12/4/15, indicted extensive assist of 1 for grooming. R23 was observed on 1/3/17, at 1:31 p.m. to have a dark substance/debris under fingernails	F 282	Care & Rehab-Ostrander strives to complete comprehensive care plans so that services can be provided or arranged by the facility as outlined by the comprehensive care plan. 1. R23's care plan was updated to reflect the need for assistance with nail care and oral care. 2. All residents who require nail care and oral care assistance did have their care plan reviewed and revised as needed. 3. Care plans will have a specific problem to reflect an increased need for assistance with ADLs. (Nail care & oral care) Information was shared with the MDS Coordinator to follow through with care planning for ADLs. 4. DON/Designee will complete audits on the care plans to assure that they are	2/14/17

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F 282	Continued From page 7 on her right hand. At 7:53 p.m. to be sitting in her wheelchair in the common area of the facility with dark brown debris underneath all of the fingernails on her right hand. R23 was observed on 1/4/17, at 10:16 a.m. to be in the common area of the facility watching television in her wheelchair again with dark brown debris underneath all of the fingernails on her right hand. R23 was observed 1/5/17 at 9:25 a.m. in the common area of the facility with dark brown debris was underneath all of the fingernails on her right hand. On 1/5/17, at 9:30 a.m. nursing assistant (NA)-A observed R23's fingernails and stated it looked like she had brown bowel movement underneath her fingernails and that R23 has a history of rectal digging. NA-A stated R23's fingernails needed to be cleaned. NA-A stated nails got done for sure on their bath days, and stated staff should be looking at fingernails after meals and when cares are completed daily. On 1/5/17, at 9:36 a.m. licensed practical nurse (LPN)-A stated she observed something underneath R23's fingernails that appeared brown, dark and black. LPN-A stated R23's nails needed to be cleaned. LPN-A stated nail cares needed to be checked daily and on the bath day. LPN-A stated R23 required extensive assist of one for grooming and stated she considered nail care to be a part of grooming. LPN-A verified R23 was dependent on staff for nail care and the care plan had not been followed for R21. A policy was requested for following the	F 282	updated with any significant change that would require increased assistance for ADLs. Audits will be completed on a weekly basis times four weeks, then a monthly basis times three months, then quarterly for one year. Findings will be shared with the Quality Assurance & Assessment Committee.	

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F 282	Continued From page 8 comprehensive care plan at this time and one was not provided.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 1 resident (R23) who was dependent on staff for meeting activities of daily living (ADLs) had clean fingernails and oral cares provided as assessed. Findings Include: R23 was observed on 1/3/17, at 1:31 p.m. to have a dark substance under fingernails on her right hand. R23 was observed on 1/3/17, at 7:53 p.m. to be sitting in her wheelchair in the common area of the facility with dark brown debris underneath all of the fingernails on her right hand. R23 was observed on 1/4/17, at 10:16 a.m. to be in the common area of the facility watching television in her wheelchair with dark brown debris underneath all of the fingernails on her right hand. R23 was observed 1/5/17 9:25 a.m. in the common area of the facility with dark brown debris was underneath all of the fingernails on her right hand.	F 312	Care & Rehab--Ostrander (C&R-O) does provide assistance for activities of daily living so the necessary services to maintain good nutrition, grooming, and personal and oral hygiene are provided. 1. R23's nails were cleaned and staff were reinformed of the need to assure the cleanliness of the oral cavity is done. 2. All other residents who were unable to perform nail care or oral care were reviewed and appropriate care was given if needed. Individual packages or nail care equipment were made up and placed in the tub room for use on bath day and any other day if needed. Education was provided on nail care and oral care and the importance of follow through. 4. DON/Designee will audit nails and oral care randomly once a week for one month, then monthly times three months, and quarterly for one year. Findings will be reported to the Quality Assurance & Assessment Committee.	2/14/17

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F 312	Continued From page 9 R23's annual Minimum Data Set (MDS) dated 12/6/16, identified required extensive assist of two for personal hygiene. R23's nursing assistant assignment guide undated, indicated extensive assist of 1 staff for grooming. R23's care plan dated 12/4/15, indicted extensive assist of 1 for grooming. R23's progress note dated 12/30/16, included, "res [resident] smearing BM [bowel movement] all over her with her hands, wiping it on her face and legs, washed her up. Res [resident] does this occasionally." On 1/5/17, at 9:30 a.m. nursing assistant (NA)-A observed R23's fingernails and stated it looked like she had brown bowel movement underneath her fingernails. NA-A stated R23's fingernails needed to be cleaned. NA-A stated nails got done for sure on their bath days, and stated staff should be looking at fingernails after meals and when cares are completed daily. On 1/05/2017, at 9:36 a.m. licensed practical nurse (LPN)-A stated she observed something underneath R23's fingernails that appeared brown, dark and black. LPN-A stated R23's nails needed to be cleaned. LPN-A stated nail cares needed to be checked daily and on the bath day. LPN-A stated R23 required extensive assist of one for grooming and stated she considered nail care to be a part of grooming. LPN-A verified R23 was dependent on staff for nail care. On 01/05/2017, at 9:56 a.m. the administrator	F 312		

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stated she expected nail care to be completed during bath time and whenever nails were soiled underneath nails.

A policy was requested for fingernail care and was not provided.

ORAL CARES AFTER INTAKE

During a family interview on 1/3/16 at 6:27 p.m. family member (FM)-A was asked, "Does R23 get the help she needs getting dressed, toileting, or cleaning her teeth?" FM-A stated sometimes he comes in after lunch and R23 still had food in her mouth.

On 1/3/17, at 7:44 p.m. R23 was observed to be watching television in the main lobby and was chewing and moving an unidentifiable red item around her mouth. Surveyor asked R23 what she had in her mouth and R23 stated it was a piece of chicken. Surveyor alerted the administrator that R23 had something in her mouth and the administrator put gloves on and removed the item. The administrator stated she was unable to identify what it was. The LPN-A approached the administrator and surveyor and stated she thought it was a piece of fruit from the jello salad she had for supper.

R23's annual Minimum Data Set (MDS) dated 12/6/16, identified required extensive assist of two for personal hygiene.

On 1/5/17, at 1:41 p.m. FM-A stated he has found R23 to have food in her mouth after meals when he had come to visit on several occasions and stated other family members have noticed as well when they are at the facility visiting. FM-A stated

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there was even a sign on R23's dresser that directed staff to, "Please provide oral cares after all oral intake."

R23's Speech Therapist Progress & Discharge Summary dated 3/24/16, instructed staff, "Sit up during PO [oral] intake, check oral cavity post PO [oral] intake to ensure food has been swallowed completely or removed by staff assist to reduce risk of aspiration/penetration of oral stasis."

R23's Therapy/Nursing Communication form dated 3/24/16, instructed staff, "Continue oral cares after meals."

R23's nursing assistant assignment guide undated, indicated extensive assist of 1 staff for oral cares, however did not direct staff on when the oral care should be completed.

R23's care plan dated 12/4/15, indicted extensive assist of 1 for oral, however did not direct staff on when the oral care should be completed.

On 1/5/17, at 1:47 p.m. nursing assistant (NA)-A stated R23 was to have her teeth brushed in the morning and evenings.

On 1/5/17, at 1:48 p.m. nursing assistant (NA)-B stated she worked the evening shift and they brushed her teeth every night before she went to bed.

On 1/5/17, at 2:11 p.m. LPN-A stated she expected R23 to have oral cares completed after intake. LPN-A stated oral cares should have been completed on Tuesday evening after dinner. LPN-A stated R23 was found to have food in her mouth around 7:44 p.m. and the oral cares

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F 312	Continued From page 12 should have been completed by then. LPN-A stated the care plan and the nursing assistant assignment guide did not indicate oral care should be completed after all meals and stated it needed to be added to the care plans. On 1/5/17, at 2:21 p.m. the administrator stated her expectation was oral care to be completed after meals if pocketing of food is occurring. The administrator stated the care plans for R23 needed to be revised to include oral cares after each meal to remove any debris left in the oral cavity. Review of the policy Formulation of Resident Care Plans, with a revised date 7/2016, included, Guideline: Each resident will have a care plan present on his/her chart that provides information for all members of the interdisciplinary care tea, regarding guidelines for individualized care. Procedure Guidelines: 5. An interdisciplinary care plan meeting will be held quarterly to review, revise, and update the plan of care. 6. Care plans will be reviewed by licensed staff quarterly.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 314		2/20/17

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F 314	Continued From page 13 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide skin care in accordance with physician orders, to promote healing and prevent further pressure ulcers from developing for 1 of 2 residents (R3) reviewed for pressure ulcers. As a result of the facility's failure to assess and provide care, R3 sustained harm when she developed additional pressure ulcers. Findings include: R3's face sheet indicated secondary diagnosis of unspecified dementia without behavioral disturbance (profound dementia), and an admission date of 9/12/14. Also included on physician visit notes dated 11/23/16, was that R3 had been losing weight due to not eating, had a fungal infection on her buttocks in November 2016, refused to be repositioned, refused to turn to side while in bed, experienced incontinence of both bladder and bowel and on that R3 was receiving hospice services. In light of these comorbidities, the facility did not promote assessment and care to prevent further pressure ulcer development. R3's significant change Minimum Data Set (MDS) assessment dated 11/20/16, indicated R3 was receiving hospice services, and required extensive assistance (two persons for physical assist) to complete transfers, bed mobility,	F 314	Care & Rehab--Ostrander does provide care and services to promote the prevention of pressure ulcer development; promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible); and prevent development of additional pressure ulcers. 1. The documentation and physician orders were reviewed on R3 to assure that all was correctly in place. Assessment of preventative measures was done and revisions were made if necessary. 2. All residents who had dependencies for movement were assessed and a review of preventative measures was done. Any revisions or updates needed were carried through. 3. Our electronic record has the ability to print an exception report. We did put in place a policy to print the exception report to assure that all tasks were completed and documented on prior to the end of the licensed staff shift. We also placed weekly skin checks in the electronic MAR for each resident to be completed by the charge nurse. Staff were trained on the electronic record, given a copy of the policy and educated on the importance of preventative measures for skin issues.	

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F 314	Continued From page 14 dressing, toileting, personal hygiene. In addition, the significant change MDS indicated R3 had moisture associated skin damage (incontinence associated dermatitis, perspiration, drainage). R3s care plan included a problem initiated 10/1/14, which indicated: potential for impaired skin integrity, with a goal to provide skin treatment to improve breakdown areas, and further identified interventions for nurses to complete included skin assessment per policy, weekly skin assessment, reduce pressure and friction, and to conduct close observation on bony prominences such as coccyx and heels. R3's Nursing Assistant (NA) assignment card (includes specific care plan interventions the NA should implement for R3) printed 1/4/17, indicated R3 had potential for impaired skin integrity. The care card indicated the NAs should assist with hygiene and general skin care, avoid using hot water for cleansing, minimize pressure on bony prominences, offer fluids with position changes, report changes to nurse, use moisturizer with cares, keep skin clean and dry, use incontinence pads, barrier cream to peri area as needed, and to keep linens clean, dry and wrinkle free. A Toileting and Repositioning Worksheet for R3 dated 1/5/17, instructed staff to check and change R3 every 2 hours. Physician Orders with a start date of 12/29/16, included directions for wound dressing changes: R3 was to have skin treatment including: cleanse wound and periwound tissue on sacrum. Pat dry. Apply skin prep and let dry. Apply Alginate Ag (a type of dressing with silver which acts as an	F 314	4. The DON/Designee will complete audits weekly for one month, monthly for three months, and quarterly for one year. Findings will be shared with the Quality Assurance & Assessment Committee.	

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antimicrobial agent) to wound bed. Apply 6 x 6 or 6 x 11 adhesive superabsorbent dressing and change twice a day AM (morning), PM (evening) until resolved, and to cleanse wound and periwound tissue on left lower buttock. Pat dry. Apply barrier paste to wound edges. Apply silver collagen to wound bed. Apply adhesive foam x 12 days AM (each morning) until resolved. The previous Physician's Order from 12/5/16, indicated a dressing change was to be completed every three days to R3's coccyx area.

R3's progress notes were reviewed in regards to pressure ulcer development:

A note dated 11/17/16 indicated weekly skin assessment: buttocks are red with a small open area (pressure ulcer #1), offload pressure from her butt, skin intact.

A note dated 12/1/16 indicated weekly skin assessment: buttocks red and skin is thin, small open area on left butt (pressure ulcer #1).

A note dated 12/5/16 identified: skin problem open area, left mid buttock (PU#2), right mid buttock (PU#3), right lower buttock (PU#4), left lower buttock (PU#1).

A note dated 12/9/16 included: optifoam dressing replaced to coccyx wound. Wound clean and dry.

A note dated 12/15/16 indicated weekly skin assessment: continues to have area on left buttock (PU#1) covered. Small open area. Resident's skin is thin and fragile and resident refuses to turn side to side.

A note dated 12/26/16 included: area is still open

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(PU#1), very fragile. Resident was turned and repositioned. New dressing applied.

A note dated 12/29/16 included: pressure ulcer unstageable (new PU#5) area on sacrum size 2 centimeters (cm) x 2 cm, no tunneling, no under minding present, moderate amount of seropurulent exudate noted. Area two left lower buttock (PU#1) size 1 cm x 1.5 cm x 0.2 cm no tunneling, no undermining present, moderate amount of serous exudate present.

Review of R3's Wound Care Skin Integrity Evaluation page 1 of 2, dated 12/21/16, included: Wound One, Sacrum, date of onset 11/21/16, indicates pressure ulcer/ Unstageable, size 2 x 2 (L x W cm) Page 2 of 2 dated 12/21/16 included: Wound Two date of onset 11/21/16, indicates Moisture associated Skin Damage 1 x 1.5 length x width centimeters (L x W cm) with a 0.2 cm depth, both wound dressing changes are to be completed twice a day.

During an observation on 1/4/17 at 8:28 a.m., R3 was observed lying in bed propped on the left side of her body. R3 was observed continuously until 10:37 a.m. to be in the same position. At 10:37 a.m., staff went into R3's room to provide care. During the care, nursing assistant (NA)-C was interviewed and stated R3 had been put to bed at 8:00 a.m. NA-C stated R3 is supposed to be repositioned every two hours. NA-C confirmed R3 had been in the same position since 8:00 a.m. (2 hours and 33 minutes). At 10:37 a.m., NA-C and NA-D were observed to reposition and change R3. During the observation it was noted the coccyx dressing had been soiled with a brownish colored matter (appeared to be feces) and there was a "gel like" substance coming from

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a tear in the dressing. After cleaning the peri-area, the nursing assistants were in the process of putting a new incontinent brief on R33, right over the obviously soiled dressing. At that time, the surveyor intervened and asked the nursing assistants what they were supposed to do when the observed a soiled dressing, both NA-C and NA-D stated they would go get the nurse.

Licensed practical nurse (LPN)-A was observed to conduct wound care and a dressing change for R3 at 11:03 a.m. on 1/4/17. LPN-A stated, "There is a pressure ulcer on coccyx and a new one starting under here," as she pointed to another area on R3's lower coccyx. During the observation, the surveyor asked LPN-A what substance was oozing out of the dressing. LPN-A said, "It's alginate [from the dressing] coming out of the wound." When asked when the dressing had last been changed and the wound assessed for size, drainage, signs of infection, etc., LPN-A stated it had been changed "last night" [1/3/17] and that measurements were done weekly. During the dressing change, R3 complained the application of the new dressing 'burned'. Upon hearing this, LPN-A removed the new dressing and stated she would call the wound nurse to see if something else could be ordered.

During observation of the dressing change 1/5/17 at 10:49 a.m., RN-A and LPN-A were assisted by NA-A. RN-A measured R3's four ulcers (two additional were identified from the day prior). The ulcers were identified to measure: Coccyx ulcer one 2 cm x 3.1 cm x 0.4 cm; wound two 0.6 cm x 0.7 cm; wound three 1.1 cm x 0.6 cm; wound four 0.8 cm x 0.4 cm, length x width x depth (L x W x D in cm). RN-A stated she was applying a silver alginate dressing cut to size, and covering it with

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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 314	Continued From page 18 an absorbent dressing to the coccyx, which was to be done twice a day. Review of the facility's Task/Treatments Summary Report for December 2016 and January 2017, revealed R3's physician had prescribed dressing treatments to both pressure ulcers twice daily. There was no documentation to identify whether or not the treatments had been completed on December 30 or 31, 2016 or January 1, 2, 3, 4 and 5, 2017. LPN-A was interviewed on 1/5/17 at 2:51 p.m., regarding facility expectations for assessment of pressure ulcers especially related to the development of R3's second, third and fourth open wounds. No additional assessment information was provided when requested. However, LPN-A verified there were now four open wounds as had been measured earlier that day. LPN-A also stated the areas were reddened at the end of November 2016, but had gotten worse. During interview with the facility's acting director of nursing (DON) at 4:15 p.m. on 1/5/17, the DON stated she would expect staff to conduct weekly skin assessments and measurements for all skin ulcers. The surveyor attempted to contact R3's medical doctor twice on 1/5/17 with no success and no return call. The facility's policy for pressure ulcer care/services was requested but was not received.	F 314		
F 323	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	F 323		2/20/17

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	245464	A. BUILDING _____ B. WING _____	01/06/2017

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F 323 SS=D	Continued From page 19 HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to complete a comprehensive falls assessment to determine if current falls interventions were appropriate or if new falls interventions needed to be developed for 1 of 2 residents reviewed (R3), who had a history of falls. Findings Include:	F 323	Care & Rehab--Ostrander does provide the residents an environment that remains as free of accidents hazards as is possible. 1. R3's had a comprehensive fall assessment completed and care plan was updated. 2. A review was completed of all falls of residents within the six months. A comprehensive fall assessment was	

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F 323	Continued From page 20 R3's face sheet indicated secondary diagnoses including unspecified dementia without behavioral disturbance (profound dementia). R3's significant change Minimum Data Set (MDS) assessment dated 11/20/16, indicated R3 received hospice services, required extensive assistance (two persons for physical assist) to complete transfers, bed mobility, dressing, toileting, and personal hygiene. The significant change MDS also indicated R3 had the ability to make self-understood and was able to understand others. Although the MDS indicated R3 had sustained no previous falls, record review indicated R3 had a fall 11/15/16, during the seven-day assessment, which was not identified on the MDS. R3's care plan printed 1/4/17, indicated R3 had been identified as a fall risk for trauma-falls, related to a history of falls since at least 10/1/14. The care plan included interventions for reducing falls such as: transfer with assistance, instruct to call for help, TAB (electronic) pad alarm when in wheelchair, provide non-skid footwear, monitor for behavior changes, monitor for drug side effects, assure adequate pain management, call button in reach, keep personal items in reach, and to use assistive devices. The goal included for R3 included: "No injury, expresses understanding of need for safety, requests assist when up." R3 was observed on 1/3/17 at 12:35 p.m. to have a bandage in place over an area on her forehead. During staff interview on 1/3/17 at 2:10 p.m. Licensed Practical Nurse (LPN)-A was asked about R3's falls, and history of injury. LPN-A	F 323	completed on falls with a revision of care plan if needed. 3. Care & Rehab--Ostrander reviewed the fall assessment in our electronic MAR. We reviewed best practices and revised and updated our program to improve our process. C&R-O also updated our immediate response to the collection of information at the time of incident. Education will be provided for licensed staff on falls, incident reports in electronic MAR. 4. DON/Designee will complete audits on a weekly basis for one month, monthly times three and then quarterly for one year.	

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F 323	Continued From page 21	F 323		

stated R3 had experienced a fall with a laceration to the forehead. Record review indicated a fall with injury had occurred on 12/29/16 when R3 had sustained the laceration to her forehead.

Review of an incident report dated 11/15/16, at 6:00 p.m. revealed R3 had been found lying on the floor on her back after having wheeled herself to her room. The incident report indicated the resident had fallen from her wheelchair when she had wanted to get into bed. No injury had been identified, and the resident's mental state was identified as normal. There was no documented investigation nor root cause analysis of the falls.

A progress note dated 11/15/16 at 9:45 p.m., verified the resident had been found on the floor earlier with no apparent injury. The progress note also indicated incident follow up x 3 days. The progress notes included no documented investigation nor root cause analysis of the fall.

A progress note dated 12/29/16 at 10:34 a.m., indicated the resident had been sent to the hospital emergency room after a fall from her wheelchair when she sustained a head laceration.

A progress note identified as a "late entry" dated 12/29/16 at 4:14 p.m., following R3's return from the emergency room, included a forehead laceration measuring 2.7 centimeters (cm) long and 0.2 cm wide had been sutured. The note also indicated R3 had sustained a laceration to the right hand which had been treated with steri strips, and that the resident had remained alert and verbally responsive and could voice her wants and needs throughout the emergency room visit.

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F 323	Continued From page 22	F 323		

Although on 1/4/17 at 11:54 a.m., the surveyor requested a copy of the incident report, assessments, vitals, neuros and any corresponding interventions related to R3's 12/29/16 fall, the only information provided was a brief summary the facility had submitted to the state Office of Health Facility Complaints (OHFC) following the resident's fall. The report submitted to OHFC included that the resident had been sleepy at the breakfast meal, awakened to eat, and that the staff had suddenly heard the resident's TAB alarm sound. Staff had then found R3 on the floor, with head and hand lacerations. Further, the report indicated R3 had been sent to the emergency room for evaluation and had returned that same day to the facility.

During interview with the director of nursing (DON) on 1/5/17 at 4:15 p.m., the DON was asked whether there had been a comprehensive fall assessment conducted for R3, and if so, what preventative measures had been identified. The DON said when a resident experienced an isolated fall, they would not necessarily update the care plan with new interventions. Therefore, no new care plan interventions had been initiated as a result of the 11/15/16 fall. The DON further verified there had not been a comprehensive assessment conducted following R3's fall with injury 12/29/16. She said the fall had occurred in the dining room with staff present so it had not been comprehensively assessed, nor had interventions been modified. When the DON was asked for a copy of the incident report for the 12/29/16 fall, none could be located.

The facility's policies related to falls were requested but none were provided.

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F 354	Continued From page 23	F 354		
F 354 SS=F	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) 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. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure eight consecutive hours of registered nurse coverage every day for seven days a week and failed to provide a full-time director of nursing. This had the potential to affect 20 of 20 residents living in the facility. Findings include: On review of nursing schedule from 11/24/16 thru 1/4/17 it was noted the follow days lacked eight consecutive hours of registered nurse coverage on 11/24/16, 11/27/16, 11/30/16, 12/7/16, 12/11/16, 12/14/16, 12/16/16, 12/17/16, 12/19/16, 12/25/16, 12/30/16, 12/31/16 and 1/1/17. During an interview on 1/4/17 at 3:50 p.m. the Administrator (also acting director of nursing) had been asked if she had full-time director of nursing. She stated, "That would be me." On asking about a waiver for not meeting the	F 354	Care & Rehab--Ostrander (C&R-O) does provide licensed staff to meet the needs of our residents. 1. C&R-O continues to advertise through Indeed, Craiglist and the local paper. 2. All RNs review the schedule closely to assure that there is as many consistent hours of RN coverage as possible. The next 14 days from today have RN coverage. 3. Calls have been extended to past workers to seek out their availability for coverage. 4. DON/Designee will complete audits to assure that ads are continued to be placed and hours covered. Audits will be done with an every two week schedule times one month, monthly times three months, and quarterly for a year.	2/20/17

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F 354	Continued From page 24 requirement for 8 hours of registered nurse coverage each day she said they do not have one but sure would like to get a waiver. On asking the administrator about what steps they have taken to hire registered nurses, she said that they are currently advertising for a full-time register nurse and a full-time director of nursing. They have advertised in Craigslist, local newspapers, and indeed (an online listing of jobs). The administrator said they use pool staff and would like to have only registered nurses but they can not supply a registered nurse when needed so they send a licensed practical nurse to cover when short staffed. Review of Administrator/Acting director of nursing print out of hours worked for 12/ 1/16 to 1/4/17 indicated that she had worked 95.3 hours, however there is no way to determine what hours was as the administrator or when working as the acting director of nursing.	F 354		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) 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:	F 356		2/1/17

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F 356	Continued From page 25 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. 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. (4) Facility data retention requirements. 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 interview and record review, facility failed to ensure the nursing hour posting was accurately completed then displayed in the facility which had the potential to affect all 20 residents in the building including visitors and staff.	F 356	Care & Rehab--Ostrander (C&R-O) does post the nurse staffing data specified on a daily basis at the beginning of each day. 1. C&R-O has posted the staffing data as required.	

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F 356	Continued From page 26 Findings include: Observation on 1/3/17, at 12:19 p.m. nursing posting hours identified the date to be 1/2/17 (day previous) with a census of 19 in facility. Interview on 1/3/17, at 12:19 p.m. with licensed practical nurse (LPN)-B verified the posting was not for the correct date and verified it was from 1/2/17. LPN-B verified there were 20 residents currently in the facility and not 19 residents as posted. Observation on 1/3/17, at 5:12 p.m. observed the same nursing hours posted from 1/2/17 even though this was brought to the facility at 12:19 p.m. same day. Interview on 1/3/17, at 6:36 p.m. with the acting director of nursing (DON) stated the nursing hour posted hadn't been changed because the person who changes it daily wasn't working today. Observation on 1/5/17, at 8:31 a.m. nursing hour posting dated 1/4/17 was posted in the facility. Interview with registered nurse (RN)-A at that time verified the wrong nursing hour posting was displayed. RN-A stated the night shift nurse must have forgotten to change it. Requested policy related to nursing hour postings but facility was unable to provide document.	F 356	2. C&R-O placed the duty of posting hours on our TO Do List in our electronic record. Audits will be done weekly for four weeks, monthly times three months, and then quarterly for one year.	

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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/04/2017**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Ostrander Care & Rehab) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/02/2017

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. (Ostrander Care & Rehab) is a 1 1/2-story building with a partial basement. The original building was constructed in 1968 and was determined to be of Type II(222) construction and meets the construction type allowed for existing buildings. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure	K 321		2/3/17

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K 321	Continued From page 2 Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from	K 321	Care & Rehab--Ostrander (C&R-O) does assure that hazardous areas are protected by a fire barrier having one hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. 1. The penetration in the ceiling of the	

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K 321	Continued From page 3 other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Findings Include: On facility tour between 09:30 AM and 01:00 PM on 1/4/2017, based on observation and interview revealed the following include: A penetration in the ceiling of the main floor laundry room around vent pipe. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 321	main floor laundry room around the vent pipe was installed on 1.26.17. 2. Audits will be completed by the maintenance man to assure any penetrations that present themselves is repaired.	

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K 346	Continued From page 4	K 346		
K 346 SS=C	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Findings Include: On facility tour between 09:30 AM and 01:00 PM on 1/4/2017, based on documentation review and interview that the following include: The out of service policy for fire alarm needs to be up-dated. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 346	1. The policy for out of service policy for fire alarm was up-dated. 2. Policies will be updated on an annual basis. 3. A calendar will be set up to track the need for updating of facility policies for emergencies.	2/2/17
K 354 SS=C	NFPA 101 Sprinkler System - Out of Service	K 354		2/2/17

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K 354	Continued From page 5 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings Include: On facility tour between 09:30 AM and 01:00 PM on 1/4/2017, based on documentation review and interview that the following include: The out of service policy for fire sprinkler needs to be up-dated.	K 354	1. The out of service policy for fire sprinkler was updated. 2. Policies will be updated on an annual basis. 3. A calendar will be set up to audit the policies for the need of updating by the maintenance man.	

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K 354	Continued From page 6 This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 354		
K 711 SS=C	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	K 711	1. The fire safety plan was updated. 2. A calendar will be set up to assure that yearly review of the fire safety plan is completed on an annual basis.	2/7/17

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K 711	Continued From page 7 Findings Include: On facility tour between 09:30 AM and 01:00 PM on 1/4/2017, based on documentation review and interview that the following include: The fire safety plan needs to be up-dated. Last up-dated was 2008. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 711		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly	K 712	1. The administrator and the maintenance man worked together to set up the fire drill calendar for the year 2017. 2. Fire drills will be conducted per Life Safety Code.	1/30/17

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K 712	Continued From page 8 on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Findings Include: On facility tour between 09:30.AM and 01:00 PM on 1/4/2017, based on documentation review and interview that the following include: Documentation review indicated that fire drills were not conduct per the Life Safety Code. 1. 1st Quarter was done twice for 1st shaft, 1-12-16 (9:45) and 3-1-31-16 (10:00). 2. 1st shaft March 31,2016 and November 18, 29,2016 were both at 10 am, 3. 2nd Quarter was done twice for 3rd shaft 4-15-16 (21:00) and 5-11-16 (22:00) This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 712	3. Audits will be conducted on a monthly basis for one year.	
K 781 SS=F	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee	K 781		2/7/17

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K 781	Continued From page 9 areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Findings Include: On facility tour between 09:30 AM and 01:00 PM on 1/4/2017, based on observation and interview revealed the following include: Four (4) space heaters were found in resident rooms. Facility has no policy for space heaters. Spare heaters were removed at time of inspection. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 781	1. All space heaters were removed from resident rooms. 2. A policy was written for space heater use. 3. Audits will be completed by maintenance man of rooms to assure that no heaters are brought into the facility for use in residents rooms	
K 918 SS=L	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		2/7/17

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K 918	Continued From page 10 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918	Care & Rehab--Ostrander has a weekly inspection checklist that shows the weekly checks were done through 11-11-16. It was on 11.18.16 that we experienced problems and called for assistance. 1. A back up rental generator was put in place on January 4, 2017. 2. Bids are being collected to determine whether a new generator will be purchased for the facility or continue with the rental agreement.	

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K 918	Continued From page 11 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Findings Include: On facility tour between 09:30 AM and 01:00 PM on 1/4/2017, based on documentation review and interview that the following include: 1. Inspection revealed the back-up generator has been out of service from May 2016. Facility Maintenance Director provided a quote from MTU Onsite Energy dated May 12, 2016 to looked at generator. The Administrator stated she give MTU Onsite Energy the approval to come out to look at generator. No further action was completed at time of inspection. We worked with Facility Maintenance Director to have Interstate Power out to look at generator. A back-up generator was delivered, hooked up to building	K 918	3. Monthly generator testing will be scheduled by the maintenance man. 4. Audits will be completed by the Administrator/Designee to assure compliance with monthly checks on a monthly basis times one year.	

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K 918	Continued From page 12 electrical system and was in-service by 10pm the same day. Administrator is working on repair and replacing existing generator. The IJ was resolved on 1-4-2017. 2. There was no record on Monthly generator testing being completed. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 918		