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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OUK2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00922

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245464**
2.STATE VENDOR OR MEDICAID NO.
(L2) **363670400**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 01/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/07/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00040
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/26/2013
(L33)

DETERMINATION APPROVAL

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

CCN = 24-5464

Ostrander Care and Rehabilitation was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on November 7, 2013. On January 2, 2014, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on November 24, 2014, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on November 7, 2013, effective December 17, 2013. Refer to the CMS-2567B for both health and life safety code.

Effective December 17, 2013, the facility is certified for 25 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245464

March 7, 2014

Mr. Lloyd Swalve, Administrator
Ostrander Care and Rehab
305 Minnesota Street
Ostrander, Minnesota 55961

Dear Mr. Swalve:

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

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

Effective December 17, 2013 the above facility is certified for:

25 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 16, 2014

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

RE: Project Number S5464025

Dear Mr. Swalve:

On November 13, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 7, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 25, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 17, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 7, 2013, effective December 17, 2013 and therefore remedies outlined in our letter to you dated November 13, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245464	A. Building B. Wing	1/2/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **12/10/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/10/2013**	ID Prefix **F0354** Reg. # **483.30(b)** LSC	Correction Completed **12/10/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/10/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/10/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/17/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	01/16/2014	31221	1/2/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/7/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245464	A. Building 01 - MAIN BUILDING 01 B. Wing	11/25/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	11/05/2013	ID Prefix Reg. # NFPA 101 LSC K0064	11/08/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	01/16/2014	31221	11/25/2013
CMS RO				

Followup to Survey Completed on: 11/4/2013

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00922	A. Building B. Wing	1/2/2014

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

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **12/10/2013**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **12/10/2013**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **12/10/2013**
ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp.** LSC	Correction Completed **12/10/2013**	ID Prefix **21630** Reg. # **MN Rule 4658.1350 Subp.** LSC	Correction Completed **12/10/2013**	ID Prefix **24580** Reg. # **MN Rule 4660.6900 Subp.** LSC	Correction Completed **12/17/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	01/16/2014	31221	01/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/7/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OUK2

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 **11/07/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kyla Einertson, HPR Dietary Specialist — 12/07/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/24/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00040 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

CCN=245464

At the time of the standard survey completed November 7, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7395

November 13, 2013

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

RE: Project Number S5464025

Dear Mr. Swalve:

On November 7, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731
Fax: (507) 206-271

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 17, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 17, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 7, 2014 (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 May 7, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245464	A. BUILDING _____ B. WING _____	11/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R15) was assessed to safely self-administer nebulizer treatment. Findings include: R15 was observed in recliner in room with nebulizer mask over nose and mouth with nebulizer solution being dispensed. R15 had been admitted on 8/2/13, with diagnoses that included shortness of breath and congestion. R15's admission Minimum Data Set (MDS) indicated moderate cognitive impairment. During the review of the signed physician orders	F 176 SPN 12/7/13		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lloyd Swalve — TITLE: Administrator — (X6) DATE: 11-27-13

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

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F 176	Continued From page 1 dated 10/23/13, it included DuoNeb (medication used to clear the bronchi) 3 milliliter solution three times a day (TID) for congestion. During observation on 11/6/13, at 11:08 a.m., R15 was sitting in their recliner located in their room with nebulizer mask over nose and mouth with nebulizer solution being dispensed. No licensed staff had been present in room or in the hallway. During interview on 11/6/13, at 11:10 a.m. licensed practical nurse (LPN)-B was unaware if an assessment had been completed for safe administration of the nebulizer for R15. During interview on 11/6/13, at 11:18 a.m., the director of nursing (DON) verified they had not completed the self-administration assessment to determine if R15 was safe to administer the DuoNeb medication independently after set up. During review of policy dated 2006, titled Self administration of medications identified residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. If the resident desires to self-administer medications, as assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process.	F 176	**F176** R15 has been clinically reassessed and deemed inappropriate for a self- medication administration. Corresponding updates have been made to the care plan. All residents have the potential to be affected. Policy and procedure "Self-Administration of Medication" has been reviewed. Self-Administration of Medication Assessment will be included in the admission packet. The Self-Medication Assessment will be reviewed on a quarterly basis and/or with a change of condition. Nursing staff will be in-serviced on the process along with the policy and procedure on December 5, 2013.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329	The Director of Nursing and/or designee will monitor the corrective actions to ensure the effectiveness of these actions including: audit of physician orders to be completed on	

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F 329	Continued From page 2 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify clinical reasons for use and implement monitoring and documentation of the effectiveness of non-pharmacological interventions related to the use of psychoactive medications for 1 of 5 residents (R17) and in addition the facility failed to complete a sleep assessment for 1 of 1 residents (R24) who was on a daily sleeping medication which was found during the review for unnecessary medications. Findings include: R17 received an antidepressant however, there had not been clinical symptoms identified as to the need for the ongoing use of	F 329	**F176- cont** a monthly basis x3 months to assure that orders are present if a resident is appropriate for self-administration of any type of medication. Upon completion of review/audits, corrective actions, if applicable, will be completed immediately. Additional education will be provided as derived from the reviews. The results of the audits with track, trend and analysis, will be reported to the facility QA committee monthly. QA committee will determine further monitoring schedule, system revision, and/or staff education to be implemented. **F329** R17- clinical symptoms have been identified. Behavior monitoring has been initiated. Corresponding updates have been made to the care plan. MD has provided documentation as to the history of medication use and the results of prior medication reductions.	12-10-13

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F 329	Continued From page 3 the medication. Also there was no monitoring if the medication was effective for R17. R17 was admitted to the facility on 10/1/2009 with diagnoses including: major depression, diabetes mellitus, chronic kidney disease, hypertension and systolic heart failure. R17's current physician orders dated 11/5/13 included an order for Wellbutrin XL 300 milligrams daily for chronic depression. The October and November 2013, medication administration record (MAR) showed R17 received the medication daily, and contained monitoring for side effects of the medication, but contained no documentation of monitoring clinical symptoms of depression or non-pharmacological interventions attempted to reduce dependency on an antidepressant medication or the use of a lesser dose of the antidepressant medication. Review of the Psychoactive Medication Quarterly Evaluation dated 9/19/13 read, Behavior warranting use of the medication: prior to stay here at the nursing home R17 said, "I wasn't very happy." R17 scored 3 on the Patient Health Questionnaire) section of the Minimum Data Set dated 3/25/13, a 3 on the MDSs dated 6/24/13 and dated 9/17/13. A score of 0-4 indicated minimal depression. Review of the medical record confirmed no tapering of the medication had been attempted nor had the physician documented a justification to continue the Wellbutrin since 3/28/11 which was 20 month ago. A Pharmacy recommendation dated 3/31/13 indicated the pharmacist had	F 329	**F329-cont** R24 - a sleep assessment has been completed. Documentation of hours of sleep will be recorded x 4 nights to establish sleep pattern. No other residents at this time are receiving a hypnotic medication. All residents have the potential to be affected. Behavior monitoring forms will be initiated for all residents receiving psychotropic medication. Behaviors will be identified along with non-pharmacological interventions. Corresponding updates have been made to the care plans. Pharmacy consultant has completed the visit to the facility on November 7, 2013. Recommendations from the pharmacist were followed up on November 11, 2013 Nursing staff will be in-serviced on the policy and procedure for behavior monitoring as well as the forms to be utilized on December 5, 2013.	

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F 329	Continued From page 4 recommended a dose reduction (tapering) for the use of the Wellbutrin XL. The physician wrote, "No further dose reduction. Has had recurrence on previous GDR [gradual dose reduction]. 2 [two] previous GDR's failed." However, this physician ' s justification lacked documentation at a minimum is to include information as to why any attempted dose reduction would be likely to impair the resident ' s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Review of the interpretive guidelines for F329 dated 1/07, provided by the facility read, " Considerations Specific to Psychopharmacological Medications (Other Than Antipsychotics and Sedatives/Hypnotics) .....After the first year, a tapering should be attempted annually, unless clinically contradicted. The tapering may be considered clinically contradicted, if: The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underling medical or psychiatric disorder. During interview with the director of nursing (DON) on 9/20/13 at 2:31 p.m., she stated the nurses chart mood concerns by exception (only if there is a symptom identified is it documented vs. documenting mood whether it is depressive in nature or not) in the progress notes, also verified that no gradual dose reduction had been attempted since admission and verified there was no comprehensive clinical justification from the physician in R17's medical record since 3/28/11	F 329	**F329-cont** Nursing staff to be in-serviced on the policy and procedure for sleep monitoring as well as the forms to be utilized on December 5, 2013. The Director of Nursing and/or designee will monitor the corrective actions to ensure the effectiveness of these actions including: audit to assure that behavior monitoring is in place for residents receiving psychotropic medication to be completed on a monthly basis x3 months. Audits will be completed monthly x3 months to assure that sleep assessments and monitoring is occurring for those residents on hypnotic-type medication. The results of the audits with track, trend and analysis, will be reported to the facility QA committee monthly. QA committee will determine further monitoring schedule, system revision, and/or staff education to be implemented.	12-10-13

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F 329	Continued From page 5 for not attempting to reduce the antidepressant medication. R24 was prescribed Navane and Melatonin for sleep however; R24 had not been comprehensively assessed for sleep patterns. R24 was admitted on 10/16/13, with diagnoses which included insomnia. An admission Minimum Data Set (MDS) dated 10/25/13, identified R24 had severe cognitive impairment. A physician order dated 10/16/13, identified R24 was prescribed Navane (antipsychotic medication) 2 milligram (mg)-2 capsules, in one week reduce to 3 mg, if tolerates reduce again in one week to 2 mg, in one week to 1 mg, in one week discontinue sleep aid; add Melatonin 3 mg 1 tablet by mouth at bedtime for sleep. However, R24's sleep cycle had not been assessed upon admission and as the medication had been tapered in dosage. Review of the medical record revealed a lack of documentation of sleep pattern and comprehensive sleep assessment. The hospital dismissal summary dated 10/16/13, revealed R24 had perhaps experienced Sundowning (Sundowning, or sundown syndrome, affects some people who have Alzheimer's disease and dementia. People with dementia who "sundown" get confused and agitated as the sun goes down -- and sometimes through the night) with disorientation and reversal of sleep wake cycle. Psychiatry had assisted with management and R24 placed on Navane and melatonin scheduled at 8 p.m. Over time with this regimen the sleep wake cycle reversed. During interview on 11/6/13, at 11:35 a.m. the	F 329		

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F 329	Continued From page 6 director of nursing (DON) confirmed R24 had received Navane and Melatonin for sleep. The DON verified if residents were on a sleep medication should have had a sleep assessment completed. The DON indicated there was a fan placed in room for the noise and verified R24's sleep cycle had improved since the first two days after admission. During interview on 11/6/13, at 3:10 p.m. the DON confirmed sleep assessment should have been completed on admission and quarterly. During review of sleep assessment policy dated 2010, directed staff to document hours of sleep as needed to determine effectiveness of sleep program, based on analyzed data from assessment, interdisciplinary team to work with resident and family on an individualized plan for assistance with sleep hygiene.	F 329		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 354	**F354** The facility has requested a waiver for RN coverage. The facility has placed an ad in the local paper for a Registered Nurse Audit tool has been developed to assist in monitoring the advertising in the local paper for a nurse. The Director of Nursing and/or designee will monitor the corrective actions to ensure the effectiveness of these actions including: routine audit to assure that advertising is in the local papers on a routine basis as a method of recruiting a nurse.	12-10-13

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F 354	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 8 hours of registered nurse coverage every day for seven days a week. This had the potential to affect 23 of 23 residents living in the facility. Findings include: The facility lacked eight hours registered nurse coverage on 10/13/13 and 10/20/13. During the review of the actual nursing schedule for 9/2013 through 10/07/2013, revealed no 8 hour registered nurse coverage on 10/13/13 and 10/20/13. During an interview on 11/6/13, at 1:04 p.m., the director of nursing verified there was no 8 hours registered nurse coverage on 10/13/13 and 10/20/13. Director of nursing (DON) verified the facility did not have a waiver for registered nurse coverage. However, they would like to apply for one. During an interview on 11/6/13, at 1:15 p.m., the administrator verified the facility did not have a waiver for registered nurse coverage. The administrator verified there had been no advertisements ran in the newspapers for registered nurses during the months of August, September, October or November 2013.	F 354	**F428** R17, R34, R7, R20 and R24 the pharmacy consultant has visited the facility and reviewed their clinical records. R17 behavior monitoring has been implemented. Pharmacy consultant has reviewed all residents in the facility as of November 7, 2013 The nursing staff, as necessary, followed up on all recommendations that were made by the pharmacy consultant. The facility is in the process of hiring a new pharmacy consultant. Nursing staff will be in-serviced on the process along with the policy and procedure on December 5, 2013. The Director of Nursing and/or designee will monitor the corrective actions to ensure the effectiveness of these actions including: Audits being completed monthly x3 months for completion of pharmacy consultant visits in a timely manner and to assure that any	
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 8 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility's consulting pharmacist did not advise the facility regarding the lack of identification for clinical use, lack of monitoring and documentation of the effectiveness of non-pharmacological interventions related to the use of psychoactive medications for 1 of 5 residents (R17); the facility failed to ensure the consultant pharmacist recommendations were acted upon for 1 of 5 residents (R17); and in addition the facility failed to ensure the consultant pharmacist completed the medication regimen review at least once a month for 5 of 5 resident (R17, R34, R7, R20, R24) reviewed for unnecessary medications. This affected all 23 residents residing in the facility. Findings Include: R17 received a daily dose of an antidepressant Wellbutrin XL however the pharmacist had not identified R17 lacked clinical symptoms for R17 determined nor was there ongoing monitoring of the Wellbutrin to determine if it was affective or not. R17 was admitted to the facility on 10/1/2009 with diagnoses including: major depression, diabetes mellitus, chronic kidney disease, hypertension and systolic heart failure.	F 428	**F428-cont** recommendations that are made are followed up by the licensed staff. The results of the audits with track, trend and analysis, will be reported to the facility QA committee monthly. QA committee will determine further monitoring schedule, system revision, and/or staff education to be implemented.	12-10-13

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F 428	Continued From page 9 R17's current physician orders dated 11/5/13 included an order for Wellbutrin XL 300 milligrams daily for chronic depression. The October and November 2013, medication administration record (MAR) showed R17 received the medication daily, and contained monitoring for side effects of the medication, but contained no documentation of monitoring symptoms or non-pharmacological interventions related to the use of the medication. Review of the Psychoactive Medication Quarterly Evaluation dated 9/19/13 read, Behavior warranting use of the medication: prior to stay here R17 said, "I wasn't very happy." Review of the medical record confirmed no gradual dose reduction of the medication had been attempted nor had the physician documented a justification to continue the Wellbutrin since 3/28/11. Pharmacy recommendations from 3/31/13 indicated the pharmacist had recommended a dose reduction for the use of the Wellbutrin XL. The documented response from the physician read, "No further dose reduction. Has had recurrence on previous GDR [gradual dose reduction]. 2 [two] previous GDR s failed." During interview with the director of nursing (DON) on 9/20/13 at 2:31 p.m., she stated the nurses chart mood concerns by exception in the progress notes, verified no gradual dose reduction had been attempted and verified there was no further clinical justification from the physician in R17's medical record since 3/28/11 for why a gradual dose reduction may be contraindicated at this time.	F 428		

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F 428	Continued From page 10 The consulting pharmacist's medication regimen reviews from 1/31/13 until 9/30/13, indicated the consulting pharmacist documented resident record reviews, but there was no documentation of irregularities related to the issues detailed above for R17. LACK OF MONTHLY PHARMACY REVIEW COMPLETED: R17 lacked a consultant pharmacist medication regimen review for October 2013. Document review of facility Pharmacist Consultant Medication Regimen Review, a log of medication reviews, revealed R17's medications were not reviewed by the pharmacist during the month of October, 2013. During interview on 11/6/13, at 11:55 a.m., director of nursing verified lack of consultant pharmacist medication regimen review since 9/30/13. R34 lacked a consultant pharmacist medication regimen review for October 2013. R34 was admitted to the facility on 8/26/2013. Document review of facility Pharmacist Consultant Medication Regimen Review, a log of medication reviews, revealed R34's medications were not reviewed by the pharmacist during the month of October, 2013. During interview on 11/6/13, at 11:55 a.m., director of nursing verified lack of consultant	F 428		

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F 428	Continued From page 11 pharmacist medication regimen review since 9/30/13. R7 lacked consultant pharmacist medication regimen review for October 2013. R7 was admitted 10/1/08. R7 diagnosis included hypertension, depression, anxiety, angina, osteoarthrosis, pain, glaucoma and hyperlipidemia. Document review of facility Pharmacist Consultant Medication Regimen Review, a log of medication reviews, revealed R7's medications were reviewed by the pharmacist on 9/30/13. The facility lacked evidence of medication regimen review since 9/30/13. During interview on 11/6/13, at 11:55 a.m., director of nursing verified lack of consultant pharmacist medication regimen review since 9/30/13. R20 lacked consultant pharmacist medication regimen review for October 2013. R20 was admitted 9/13/11. R20 diagnosis included Alzheimer ' s disease, depression, anxiety, pain and pemphigoid rash. Document review of facility Pharmacist Consultant Medication Regimen Review, a log of medication reviews, revealed R20's medications were reviewed by the pharmacist on 9/30/13. The facility lacked evidence of medication regimen review since 9/30/13. During interview on 11/6/13, at 11:55 a.m., director of nursing verified lack of consultant pharmacist medication regimen review since	F 428		

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 _____	11/07/2013

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

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F 428	Continued From page 12 9/30/13. R24 was admitted on 10/16/13, and was not seen by consultant pharmacist for the month of October 2013. During interview on 11/6/13, at 2:27 p.m. the facility consultant pharmacist verified they had been late this month (reference to October) and had not reviewed medication regimens for the month of October for the residents. Pharmacy consultant indicated they had no excuses and would come in on this Friday November 8, 2013. Review of the CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS dated 2006 read, "F, The specific activities that the consultant pharmacist performs includes, but is not limited to: 1) Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions, incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review (see IIIA1: MEDICATION REVIEW (MONTHLY REPORT), and documenting the review and findings in the resident's medical record."	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	**F431** Facility policy reviewed as it relates to the destruction/disposable of narcotic medication (fentanyl patch) A form has been developed and implemented that records the two staff member signatures for the destruction of the fentanyl patch. The Director of Nursing and/or designee will monitor the corrective actions to ensure the effectiveness of these actions including: Audits being completed twice a week x 3 months for two licensed staff signatures recorded for the disposal of a narcotic patch. The results of the audits with track, trend and analysis, will be reported to the facility QA committee monthly. QA committee will determine further monitoring schedule, system revision, and/or staff education to be implemented.	12.10.13

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F 431	Continued From page 13 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to document destruction of fentanyl patches (a narcotic used for moderate to severe pain) and the facility had not followed the current recommendations for disposal of medication and not use the sewer system to destroy medications vs. throwing in trash for destruction to reduce contamination of our water supply. This practice could encourage diversion of pain medications by staff, residents and/or visitors.	F 431		

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F 431	Continued From page 14 Findings include: The facility had not documented actual disposition of used fentanyl patches and they were flushed down the sewer system. During interview on 11/4/13, at 7:08 a.m. the director of nursing (DON) thought the nurses " rolled-up " the used fentanyl patch in the disposable staff gloves and then disposed of the patch in the waste basket. During interview on 11/4/13, at 7:09 p.m. licensed practical nurse (LPN)-A indicated the process for disposing of used fentanyl patch included after fentanyl patch had been removed from a resident the patch was placed in the package and placed in the garbage. During interview on 11/5/13, at 9:46 a.m. LPN-B identified the process had been once been to take the patch then they placed the sticky side forward in the gloves and then they threw it in the waste basket located on the cart, and never in the resident room. LPN-B verified they had not had anyone co-sign the removal/destruction of fentanyl patches when removed from the residents. During interview on 11/6/13, at 2:20 p.m. the facility consultant pharmacist verified fentanyl patches once removed may still potentially contained 20-40 percent of the medication on the patch. The consultant pharmacist indicated the used patches should not be disposed of in the trash as they are currently doing in the facility. The pharmacist ' s recommendation had been to place the used fentanyl patch in the sharps	F 431		

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F 431	Continued From page 15 container (container that is used to prevent unauthorized access to content for safety reasons.) the consultant pharmacist recommended if not able to have two staff destroy fentanyl patch to then fix the patch to a piece of paper for the pharmacist and nurse to destroy on a monthly basis as two persons are to witness destruction due to fentanyl being classified as a narcotic. The Food and Drug Administration (FDA) recommended disposing of used patches by folding them in half with the sticky sides together, and then flushing them down a toilet. They should not be placed in the trash. FDA recognizes that there are environmental concerns about flushing medicines down the toilet. However, FDA believes that the risk associated with accidental exposure to this strong narcotic medicine outweighs any potential risk associated with disposal by flushing. This article was updated September 23, 2013. The facility had no policy specific for destruction of fentanyl patches.	F 431		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain food service areas in good repair and in a sanitary manner,	F 465	**F465** The facility will secure bids for the total replacement of the floor in the kitchen, corridor, and janitor's closet. Target date for accepting a bid is Dec. 31, 2013. The Dietary Department will develop a Policy & Procedure addressing floor sanitization for the newly installed floor. The Administrator is responsible for project completion.	12/17/13 → 1.31.14

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F 465	Continued From page 16 potentially affecting 23 of 23 residents residing in the facility. Findings include: During the kitchen tour on 11/4/13 at 12:15 p.m. with the certified dietary manager (CDM) the following concerns were identified: The flooring in the entire kitchen which included the walk in cooler, janitor closet and back hallway had multiple chips missing, gouges and cracks especially in the area of the walk in cooler and janitor closet. This created a non-sanitized surface. During an interview on 11/5/13 at 12:10 p.m., during the kitchen tour, the CDM verified the concerns with the flooring in kitchen and verified this created a non-sanitized surface. The CDM stated there had been discussions held regarding the condition of the kitchen flooring; however there was nothing in the budget at this time to replace flooring. During an interview on 11/5/13 at 2:12 p.m., the administrator stated he was unaware of any concerns with the kitchen flooring and verified there was no plan in place to replace the kitchen flooring. During a tour through the kitchen on 11/5/13 at 2:17 p.m., the administrator verified the flooring in the kitchen, back hallway; janitor closet and walk in cooler had had multiple chips missing, gouges and cracks. The administrator verified this created a non-sanitized surface. The facility did not have a policy regarding sanitization of the kitchen flooring per the CDM.	F 465		

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	245464	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/04/2013

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Ostrander Care and Rehab was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	POC ok B 11-22-13 RECEIVED NOV 21 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DOC: 12-17-13

EXIT: 11-7-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lloyd L. Swalve	Administrator	11-21-13

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ostrander Care and Rehab is a 2-story building, with a partial basement. This facility was constructed in 1968 and was determined to be of Type V(000) construction. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 25 beds and had a census of 23 beds at the time of the survey.	K 000		
K 062 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 062	Continued From page 2 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 5-3.2.1. This deficient practice could affect all 23 residents. Findings include: On facility tour between 1:00 PM and 3:00 PM on 11/04/2013, the review of the quarterly flow alarm test report revealed that there is no documentation for quarter flow alarm test since fire alarm system installed on 01/04/2013. This deficient practice was confirmed by the Director of Maintenance (TF) at the time of discovery.	K 062	**K062** **Quarterly Flow Test was conducted.** **Tom Frederick, Plant Engineer, is responsible for conducting the quarterly test.**	11-5-13
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	**K064** **Advanced Fire Protection conducted an inspection of the fire extinguishers.** **Tom Frederick, Plant Engineer is responsible for assuring that annual inspections are scheduled and conducted.**	11-8-13

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K 064	Continued From page 3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. The deficient practice could affect all 23 residents. Findings include: On facility tour between 1:00 PM and 3:00 PM on 11/04/2013, the review of the fire extinguisher annual inspection documentation for the past 12 months revealed, that the facility failed to conduct the annual fire extinguisher inspection with-in 12 months. The last Advance Fire Protection annual inspection report was dated 09/26/2012. This deficient practice was confirmed by the Director of Maintenance (TF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 064		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7395

November 13, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5464025

Dear Mr. Swalve:

The above facility was surveyed on November 4, 2013 through November 7, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Dr SE, Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)
cc: Licensing and Certification File