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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W1VC

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 **02/19/2016** (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:
___1. Acceptable POC

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 :
Lisa Carey, HFE NE II 02/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/02/2016 (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

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of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245464

March 2, 2016

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

Dear Ms. Rauk:

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

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

Effective February 9, 2016 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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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Electronically delivered
February 25, 2016

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

RE: Project Number S5464027

Dear Ms. Rauk:

On January 20, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 31, 2015. 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 February 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 9, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 31, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 9, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 31, 2015, effective February 9, 2016 and therefore remedies outlined in our letter to you dated January 20, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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	2/19/2016 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 F0170	Correction	ID Prefix F0241	Correction	ID Prefix F0247	Correction
Reg. # 483.10(i)(1)	Completed	Reg. # 483.15(a)	Completed	Reg. # 483.15(e)(2)	Completed
LSC	01/21/2016	LSC	02/09/2016	LSC	01/30/2016
ID Prefix F0250	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.15(g)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	02/09/2016	LSC	02/09/2016	LSC	02/09/2016
ID Prefix F0312	Correction	ID Prefix F0315	Correction	ID Prefix F0371	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(d)	Completed	Reg. # 483.35(i)	Completed
LSC	02/09/2016	LSC	02/09/2016	LSC	01/11/2016
ID Prefix F0425	Correction	ID Prefix F0441	Correction	ID Prefix F0492	Correction
Reg. # 483.60(a),(b)	Completed	Reg. # 483.65	Completed	Reg. # 483.75(b)	Completed
LSC	02/09/2016	LSC	02/09/2016	LSC	02/09/2016
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	2/25/2016	34985	2/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/31/2015	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245464	A. Building 01 - MAIN BUILDING 01 B. Wing	2/9/2016

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 Reg. # NFPA 101 LSC K0038	Correction Completed 02/09/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 01/30/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 01/30/2016
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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 2/25/2016	SIGNATURE OF SURVEYOR 35482	DATE 2/9/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/30/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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Electronically delivered

February 25, 2016

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

Re: Reinspection Results - Project Number S5464027

Dear Ms. Rauk:

On February 19, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 19, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00922 Y1	A. Building B. Wing Y2	2/19/2016 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 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20302	Correction	ID Prefix 20435	Correction	ID Prefix 20560	Correction
Reg. # MN State Statute 144.6503	Completed	Reg. # MN Rule 4658.0210 Subp. 2 A.B.	Completed	Reg. # MN Rule 4658.0405 Subp. 2	Completed
LSC	02/09/2016	LSC	01/30/2016	LSC	02/09/2016
ID Prefix 20565	Correction	ID Prefix 20860	Correction	ID Prefix 20910	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 2 F.	Completed	Reg. # MN Rule 4658.0525 Subp. 5 A.B	Completed
LSC	02/09/2016	LSC	02/09/2016	LSC	02/09/2016
ID Prefix 21015	Correction	ID Prefix 21375	Correction	ID Prefix 21426	Correction
Reg. # MN Rule 4658.0610 Subp. 7	Completed	Reg. # MN Rule 4658.0800 Subp. 1	Completed	Reg. # MN St. Statute 144A.04 Subd. 3	Completed
LSC	01/11/2016	LSC	02/09/2016	LSC	02/09/2016
ID Prefix 21805	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # MN St. Statute 144.651 Subd. 5	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/21/2016	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	2/265/2016	34985	2/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/31/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W1VC

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 **12/31/2015** (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 :
Michele McFarland, HFE NE II 02/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/25/2016 (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

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
January 20, 2016

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

RE: Project Number S5464027

Dear Ms. Rauk:

On December 31, 2015, 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;

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 9, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 9, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the

level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 31, 2016 (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 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245464	A. BUILDING _____ B. WING _____	12/31/2015

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 170 SS=F	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that residents received their personal mail on Saturdays. This deficient practice had the potential to effect all 19 residents in the facility. Findings Include: On 12/29/15 at 3:47 p.m. a resident (R18) who attends resident council was interviewed and stated, "We never get Saturday mail. The staff are not here on Saturday to pick up the mail."	F 170	1. Mail will be picked up and delivered by staff on a daily basis when there is mail delivery. 2. Audits will be completed on every Saturday for one month, then monthly times three months, and then quarterly for one year. Audits will be shared at QAA Meetings on a quarterly basis.	1/21/16

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

Electronically Signed | 01/26/2016

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F 170	Continued From page 1 On 12/30/2015 at 11:04 a.m. the activity/social services director (ASSD) stated mail was delivered to the residents Monday through Friday. The ASSD stated the residents do not get their mail on Saturdays because the mail is delivered to the post office and there was not staff on the weekends to pick up any mail on Saturday for residents. The ASSD was unaware of the post office hours on Saturday. On 12/30/2015 at 2:02 p.m. nursing assistant (NA)-C stated on the weekends there was one nurse and two nursing assistants working and they do not have the staff to pick up the mail from the post office on Saturdays. NA-C stated a previous post office worker would deliver the mail to the facility on Saturdays but stated that person no longer works at the post office. On 12/30/2015 at 3:19 p.m. the administrator stated she was aware of the residents right to receive mail unopened and on Saturday. The administrator stated she would have to think about how the facility would manage this and would have to look at a plan. The administrator stated she was aware the facility had two employees that took turns during the weekdays getting the mail, but had not thought about Saturday. The undated Mail Policy indicated, "1. The resident have the right to send and promptly receive mail that is unopened ... 3. Prompt delivery of mail or other materials to the resident within 24 hours, except when there is no regularly scheduled delivery and pick up-service."	F 170		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		2/9/16

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F 241	Continued From page 2 The facility must 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to treat 1 of 1 resident (R24) with dignity when an incontinent product was partially visible to anyone in the area had been placed underneath R24 while seated in her wheelchair and failed to provide a dignified dining experience for R24. Findings Include: INCONTINENCE PAD VISIBLE WHILE SEATED IN WHEELCHAIR LOCATED IN COMMON AREA: R24, was observed on 12/29/2015 at 6:29 p.m. located in the common area of the facility near the television sitting in a wheelchair with a visible plastic incontinent chuck pad (a pad used to absorb urine) placed underneath her on the cushion of the wheelchair. There were five other residents sitting in the same common area at this time. On 12/29/2015 at 6:50 p.m., R24 continued to be observed in the common area of the facility sitting in a wheelchair with the plastic incontinent chuck pad placed underneath her. There were five other residents sitting in the same common area. On 12/29/2015 at 7:03 p.m. R24 continued to be	F 241	1. Education will be provided to all staff that an incontinent product is not to be visible when it is necessary to be used for a resident. Also the importance of providing dignified dining experience for Resident 24. 2. A review of all residents will be completed to assure that there was not another resident affected by this practice. A review of dining protocol was completed and changes were made to assure that the dining experience is completed in a dignified manner. 3. Education will be provided to all staff by February 15, 2016 to review the importance of dignity being provided while caring for them. 4. Monitors will be completed on a weekly basis for a month, then monthly for three months and then quarterly to assure continued appropriate practices. Reports will be submitted to the QAA Meeting on a quarterly basis.	

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F 241	Continued From page 3	F 241		

observed in the common area of the facility sitting in a wheelchair with the plastic incontinent chuck pad placed underneath her. There were five other residents sitting in the same common area.

R24's quarterly Minimum Data Set (MDS) dated 12/8/15, revealed R24 had a brief interview for mental status score of 0, which indicated severely impaired cognition, R24 required extensive assist of two for toileting and identified a diagnoses of Alzheimer's disease.

On 12/29/2015 at 7:16 p.m., licensed practical nurse (LPN)-B stated a plastic incontinent chuck pad should not have been placed underneath R24 in her wheelchair. LPN-B stated R24 wore a brief for incontinence and stated the visible chuck pad was a dignity issue. On 12/29/2015 at 7:17 p.m., LPN-B verified through observation the plastic incontinent chuck pad was placed underneath R24 in her wheelchair and she was sitting in her wheelchair in a common area of the facility which was visited by staff, families, and residents.

On 12/29/2015 at 7:18 p.m., the administrator verified through observation the plastic incontinent chuck pad was placed underneath R24 in her wheelchair. The administrator stated this would not be something they would practice here at the facility. The administrator stated this was a dignity issue for the R24 and stated she was astounded and would make sure that did not happen again.

On 12/29/2015 at 7:22 p.m., a nursing assistant was observed to take R24 back to her room. A gait belt was placed around R24's waist and she required an assist of two nursing assistants to

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F 241	Continued From page 4	F 241		

stand. The plastic incontinent chuck pad was removed from the wheelchair, was replaced with a cloth incontinent chuck pad and R24 was sat back down in the wheelchair. Nursing assistant (NA)-D stated they placed the chuck in her wheelchair as R24 was incontinent and she had soaked through her brief and her pants earlier.

On 12/29/2015 at 7:32 p.m., the administrator stated it would not be appropriate to use a cloth incontinent chuck pad in R24's wheelchair and verified the cloth chuck pad would also be a dignity issue for resident. On 12/29/2015 at 7:35 p.m. the administrator verified through observation R24 was sitting on a cloth incontinent chuck pad in her wheelchair in the hallway.

On 12/29/2015 at 7:38 p.m., the administrator stated R24 had soaked through her brief earlier and the cushion in her wheelchair was wet. The administrator stated the nursing assistants told her the incontinent products were placed in R24's wheelchair to protect her clothing from getting wet from the cushion. The administrator stated this was still not a good reason to place the chuck incontinent pads in R24's wheelchair. The administrator stated she educated the nursing assistants on dignity for the resident.

On 12/29/2015 at 7:46 p.m., R24 was observed to be sitting in the hallway in the wheelchair with a visible cloth incontinent chuck pad underneath her.

EVEN THOUGH R24 RECEIVED ADEQUATE FOOD THERE LACKED A DIGNIFIED DINING EXPERIENCE:

R24 had been observed on 12/30/2015 at 9:09

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F 241	Continued From page 5	F 241		

a.m. located in the dining room with licensed practical nurse (LPN)-C sitting by R24 assisting her to eat her breakfast. At 9:26 a.m., the telephone hanging on the dining room wall rang, LPN-C left R24 sitting at the table to answer the phone and then left the dining room. LPN-C returned to the dining room at 9:28 a.m. walked over to R24 and asked if she would like another bite and then proceeded to leave R24 at the dining room table and walk to the medication cart which was located outside of the dining room. At 9:30 a.m. LPN-C came back into the dining room, walked around the room as R24 was independently drinking a beverage at this time. At 9:31 a.m. LPN-C again went to the medication cart positioned right outside of the dining room. At 9:31 a.m.. LPN-C reentered the dining room and sat down by R24 and offered to assist her to eat more food. R24 accepted a bite of sausage and a drink of apple juice. LPN-C attempted to provide resident another bite and R24 turned her head away. LPN-C encouraged R24 to drink more of her fluids. R24 accepted drinks of her milk. LPN-C offered another bite of her sausage and R24 accepted the bite of food. LPN-C offered R24 a drink of her juice and R24 took the cup and started to independently drink her juice. LPN-C got the attention of a surveyor and asked if the surveyor had time to watch her continue to complete the medication pass. LPN-C then left R24 sitting at the table with her plate of food and three beverage glasses sitting in front of her. R24 moved the plate around on the table and placed food in one of the cups. There was no staff member present in the dining room at this time. LPN-C was at the medication cart outside of the dining room, preparing medications for another resident. R24 picked up pieces of her food and placed them back down on her plate with her

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F 241	Continued From page 6	F 241		

hands, R24 picked up a piece of her sausage and placed it in her mouth. There is no staff member present in the dining room at this time. At 9:42 a.m. LPN-C reentered the dining room to administer another resident their medication. R24 continued to pick up the food off of her plate and place it back down on her plate. At 9:44 a.m. LPN- C again left the dining room to go to the medication cart and there was no staff in the dining room. R24 started to fold the bottom of her clothing protector on top of the dining room table as it was still fastened around her neck. At 9:45 a.m. LPN-C sat back down by R24 and LPN-C used a fork to remove food from one of the cups and started offering R24 drinks of milk and offered her another bite of her sandwich. R24 accepted the bite of the food. Offered resident drink of milk and R24 accepted another bite of food. R24 picked up a piece of the grilled cheese and took a bite independently. R24 accepted another bite of grilled cheese from the nurse and accepted a drink of milk. At 9:51 a.m. R24 accepted another bite of her grilled cheese sandwich. R24 picked up one of her cups and took a drink independently. R24 accepted another bite of food at 9:52 a.m., 9:53 a.m. and 9:55 a.m. LPN-C asked R24 if she would like a cookie. LPN-C knocked on the kitchen door and asked for a soft cookie for R24. LPN-C unwrapped the cookie from the plastic bag and sat the plastic wrapper on the table. LPN-C proceed to clean a table top in the dining room. At 10:01 a.m. LPN-C walked back over to R24, asked her how the cookie was, removed her plate of food then went to the medication cart. At 10:03 a.m. LPN-C reentered the dining room and asked R24 if she was done. At 10:06 a.m. LPN-C wheeled R24 out of the dining room to the day room.

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F 241	Continued From page 7 R24's quarterly Minimum Data Set (MDS) dated 12/8/15, revealed R24 had a brief interview for mental status score of 0, which indicated severely impaired cognition, R24 required limited assist of one for eating and identified a diagnoses of Alzheimer's disease. R24's care plan dated 9/22/15 indicated R24 required limited assist of one staff for eating at times, but at least supervision, with cues to keep on task. R24's nurse progress noted dated 12/8/15 indicated, "Eating. Requires one aide for assist for eating to feed resident for all meals eating ability has decreased. Usually eats 75%, has good appetite, no eating concerns or swallowing problems." On 12/31/2015 at 9:19 a.m. LPN-B stated R24 was to receive assist of one to eat. LPN-A stated R24 was able to hold her own glass independently drink and was able to eat finger food independently. LPN-B stated her care plan indicated for meal time R24 required assist of 1 at times, but at least supervision with cues. LPN-B stated her expectation was staff should sit with R24 until she completed her meal. LPN-B verified R24 did not receive a dignified dining experience when the nurse did not supervise R24 during the meal and R24 was observed to play with her food. On 12/31/2015 at 9:29 a.m., the administrator stated she expected staff to provide attention to residents in the dining process. The administrator verified R24 was not treated with respect and dignity when she was having her breakfast during	F 241		

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F 241	Continued From page 8 the observed dining experience. An untitled and undated policy on dignity indicated, "We will treat patients, colleagues and visitors with respect, dignity and compassion."	F 241		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to give appropriate notice of incoming roommates for 1 of 1 resident (R13) who received two new roommates. Findings Include: R13 was interviewed on 12/29/15 at 2:32 p.m., R13 indicated she had roommate changes and had not been notified previously of getting a roommate. On 12/30/2015 at 11:01 a.m. the activity/social services director (ASSD) stated she was aware R13 had a roommate move into her room in September 2015 when her current roommate moved in. The ASSD stated she did not document roommate change notifications and was not sure if another staff member did. The ASSC stated she was not involved in the process of notifying a resident they were getting a new roommate. The ASDD stated she could not confirm or deny whether residents were getting	F 247	1. Resident 13 does have a roommate at this time and is aware of that. 2. A policy was developed to make sure that all residents are notified of a change in room or roommate. 3. Staff will be educated on the new policy and where and when to document room changes and the notification of the resident of such an occurrence. 4. A follow up will be completed by administrative nursing to assure that documentation and notification did occur regarding change of room and roommate. The DON/Designee will complete the review after each room/roommate change monthly times three months and then quarterly for one year.	1/30/16

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F 247	Continued From page 9 informed of new roommates as she was not responsible at this time for informing them. On 12/30/2015 at 2:21 p.m., licensed practical nurse (LPN)-B stated normally if a resident was going to get a new roommate we let the resident and family know. LPN-B stated the notification would be documented under the social services progress notes. On 12/30/2015 at 3:27 p.m., the administrator stated residents should be notified they are getting a new roommate prior to the resident moving in. The administrator stated staff should document the notification in the resident's medical record. On 12/31/2015 8:48 a.m., the business office manager verified R13 had two new roommates in the year 2015. R13 had a new roommate move in on 8/3/15 and 9/30/15. A policy on notification of a new roommate was requested and not provided.	F 247		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to evaluate and	F 250	1. R3 was seen by her attending physician. It was decided by her attending	2/9/16

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F 250	Continued From page 10 implement interventions after an increase in symptoms of depression was identified following a fracture with hospitalization and a titration of an anti-depressant and an acute change in condition for 1 of 1 resident (R3). Findings include: R3 was hospitalized from 9/2/15 to 9/8/15 for surgical repair of a fractured leg. Following the return back to the facility from the hospitalization R3 displayed an increase in physical and verbal behaviors and a substantial increase in symptoms of depression. R3's record did reflect the facility evaluated the assessment data to develop a plan of care for the increase behaviors and depressive symptoms. In addition, the record did not reflect R3's physician had been notified timely of R3's deterioration of mood and behaviors. R3 received Remeron (antidepressant medication) dosage which was decreased from 7.5 milligrams (MG) every other day to 7.5 mg every 3rd day on 6/10/15 and currently takes 7.5 mg ever three days according to the physicians orders. R3's physician signed Provider Orders dated 11/10/15 included diagnoses of major depressive disorder and dementia without behavioral disturbance. R3's significant change Minimum Data Set (MDS) dated 8/18/15 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 14. The Patient Health Questionnaire-9 (PHQ-9, mood-monitoring assessment) indicated a score of 1 with depressive symptoms of feeling tired or having little energy for several days out of the assessment period. MDS reflected R3 did not have any behaviors during the assessment period. The MDS reflected the diagnosis of depression with the use of an antidepressant medication.	F 250	not to increase her anti-depressant. 2. Reviewed all residents PHQ-9s (current and prior) for any significant increase or decrease and followed through accordingly. 3. PHQ9s and Geriatric Depression Scale is completed on all admission, quarterly, and with significant changes. They will be reviewed with the previous PHQ9 to determine if a care plan needs to be implemented or revised. 4. DON/Designee will complete audits on careplans and PHQ9s on a monthly basis for three months and then quarterly for one year to assure continued compliance. Reports will be given at QAA Meeting on a quarterly basis.	

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F 250	Continued From page 11 R3's significant change MDS dated 9/15/15 indicated no cognitive impairment and had the same PHQ-9 score with the same symptoms and frequency. The MDS also reflected R3 had no behaviors and used an antidepressant medication. The MDS reflected the diagnosis of depression with the use of an antidepressant medication. R3's 14 day MDS dated 9/22/15 indicated no cognitive impairment and R3 displayed physical and verbal behaviors. The PHQ-9 showed an increase in mood symptoms with a score of 8. The PHQ-9 indicated R3 felt little interest or pleasure in doing things nearly every day, feeling tired or having little energy more than half of the time, and having poor appetite or over eating nearly every day. The MDS reflected the diagnosis of depression with the use of an antidepressant medication. The Care Area Assessment for Psychotropic medication use gave the following information, "Resident is on an antidepressant that has been decreased to every 3 days. She has been doing well on this dose. She is followed by a pharmacist and physician for possible drug reductions when appropriate. Staff monitor her mood each shift and for adverse side effects of medication. Will develop care plan, continue current plan." R3's significant change MDS dated 12/8/15 indicated no cognitive impairment. The MDS continued to show no change in the PHQ-9 score of 8 and no change in the mood indicators. R3's current signed physician orders dated 11/10/5 included Remeron 7.5 milligrams (mg) by mouth every three days. The 7.5 mg dose every three days was the result at an attempt of a gradual dose reduction that started on 6/10/15. The previous does up until 6/10/15 had been 7.5 mg every other day. A physician visit note dated	F 250		

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6/10/15 included, "History of depression. Note that on 2/4 we decreased her Mirtazapine [Remeron] 7.5 mg every other day and her PHQ-9 score still remains zero. We will decrease it to every 3rd day for a couple of months and if she is tolerating this, then we will stop. The physician saw R3 on 8/11/15 and on 9/9/15, however no Physician visit notes addressing R3's decline in depression/behaviors as found during the 14 day MDS dated 9/22/15.

R3's electronic care plan was provided by the facility on 12/30/15. The care plan identified the use of an anti-depressant medication and included the direction to staff to monitor for adverse side effects, evaluate effectiveness and adverse side effects of medication, report unusual behavior, change in physical condition, and report change in appetite. The care plan did not reflect changes since the increase in depressive symptoms identified on the PHQ-9 assessment.

R3's mood/behavior log/documentation was reviewed from August to December 2015. According to the documentation prior to the hospitalization R3's mood and behaviors were stable. August documentation reflected one entry on 8/18/15, "chronic behavior; cursing at others behavior occurred 1-3 days in the last seven days." After R3's hospitalization mood/behavior documentation indicated a substantial increase in episodes of verbal and physical behaviors and depressive symptoms. Documentation on 9/16/15 reported the behaviors put the resident at significant risk for physical illness or injury, interfered with resident care, significantly interfered with resident's participation in activities or social interaction, and put others at risk for physical injury. The record did not reflect a comprehensive reassessment and evaluation of

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the increase in mood or behaviors.
During an interview on 12/30/15, at 10:30 a.m. assistant director of nursing (ADON) and licensed practical nurse (LPN-B) was asked, "What was done with increase in PHQ-9 score?" ADON stated, the resident doesn't come out of her room or socialize and that's hard. ADON stated she performed doctors rounds; she had not notified the physician of R3's deterioration in behavior and depression and the physician should have been notified. In response to the question, "What assessments and evaluation were performed as a result of increase in behaviors and depressive symptoms?" ADON indicated she was not aware and would have to check with the administrator.
During an interview on 12/30/15, at 2:52 a.m. social worker (SW)-A indicated she had conducted the PHQ-9 assessment and was aware of the increase in depressive symptoms. SW-A stated she did not do an evaluation of the data collected for the assessment, and the physician was not notified of the change in the PHQ-9 score because the score of 8 only indicated mild depression, the physician would be notified of a score of 9 or higher.
During an interview on 12/31/15, at 10:07 a.m. LPN-C stated a noticeable increase in verbal and physical behaviors after hospitalization and as time went on the behaviors improved. LPN-C reported not knowing why the behaviors had changed. LPN-C stated R3 does not like change and did not want to go to the hospital.
During an interview on 12/31/15, at 9:06 a.m. SW-A indicated the steps that were taken was trying to get her to go to activities because she refuses to come out of her room and only likes to do nails. SW-A stated the power of attorney wants us to encourage activities and wants R3 out of room more. SW-A stated prior to R3

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F 250	Continued From page 14 moving to a nursing home, life pattern for years was to stay at home with the blinds closed and watch TV. SW-A stated, "I felt that having her out of her room because of social isolation was the best thing for her." SW-A stated we do not force activities on her. An evaluation of the R3's social tolerance was not located in the record. SW-A stated one on one visits for activities and social services is on the care plan, and visits had occurred, however, SW-A stated there was no documentation or calendar of visits. During an interview on 12/31/15, at 10:44 a.m. nursing assistant (NA)-A stated R3 was difficult after she broke her leg; R3 displayed more behaviors. NA-A stated the physical and verbal behaviors subsided when therapy was completed. NA-A reported allowing R3 to stay in her room and in bed to decreased the behaviors; R3 would get mad at us for telling when it was therapy time. A facility policy was requested and not received.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		2/9/16

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F 279	Continued From page 15 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions that included individualized toileting schedules for 2 of 2 residents (R3,R6) reviewed for incontinence and in addition the facility failed to develop care plan interventions for Coumadin (blood thinner medication) and digoxin (heart rate control medication) for 1 of 5 residents (R23) reviewed for unnecessary mediations. Findings include: LACK OF INDIVIDUALIZED TOILETING SCHEDULE BASED ON COMPREHENSIVE ASSESSMENT: R3 was hospitalized from 9/2/15 to 9/8/15 following a fall with femur fracture resulting in decrease of mobility and an increase in staff assistance for toileting. Following hospitalization, R3's urinary incontinence increased from frequently to always incontinent. The facility failed to develop a comprehensive urinary care plan to reflect the changes of R3's voiding habits. R3's significant change Minimum Data Set (MDS) dated 12/8/15 indicated no cognitive impairment with a Brief Interview for Mental Status score of 15. The significant change MDS dated 9/15/15 indicated no toileting program or trial, frequently incontinent of urine and required extensive assist of two staff for toileting. R3's 14 day MDS dated 9/22/15 indicated no toileting program or trial,	F 279	1. R3 and R6's care plans were reviewed and revised to indicate individualized scheduled toileting. R 23's care plan was updated for the Coumadin and digoxin administration and monitoring. 2. All care plans will be reviewed and updated as needed for toileting and medication administration. 3. A policy will be developed and implemented on care plan initiation and revisions. 4. DON/Designee will complete audits for care plan completion and accuracy on incontinent resident and those who have specific medication needs (coumadin & digoxin etc.) on a weekly basis for one month and then monthly times three months and then quarterly. Results of audits will be shared at quarterly QAA Meetings.	

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always incontinent of urine and required extensive assist of two staff for toileting. The significant change MDS dated 12/8/15 indicated no toileting program or trail, always incontinent of urine and required extensive assist of one staff for toileting. The associated urinary care assessment area (CAA) indicated R3 had urge incontinence and required assistance for transferring and perineal care. The CAA included, "She is incontinent quite often but will alert staff to need to use the toilet. Incontinence products are managed by staff and pericare is completed after incontinence episodes. Will develop Care Plan."
Facility Bladder assessment dated 12/8/15 indicated resident is usually aware of toileting needs and expresses acceptance of incontinence. Assessment further indicated R3 voided correctly, without incontinence, less than once per day and the incontinence is in small amounts. The assessment identified the type of urinary incontinence as mixed.
R3's electronic care plan provided by the facility on 12/30/15 indicated R3 had urge incontinent and unable to reach bathroom/commode in time related to mobility deficit. The care plan directed staff to encourage intake, and report changes in voiding patterns or appearance in urine. The care plan did not direct staff of R3's toileting routines or needs. The care plan did not reflect the assessed type of incontinence (mixed).
R3's CNA Assignment Card did not reference an individualized toileting schedule or plan.
R3's voiding diary was reviewed form 10/1/15 through 12/30/15. The diary reflected always incontinent of urine.
During an interview on 12/30/15, at 9:51 a.m. nursing assistant (NA)-A indicated R3 used to put on her call light prior to her fall to use the restroom. NA-A explained R3 didn't use the call

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F 279	Continued From page 17 light at all anymore to use the bathroom and calls when she is wet so we can change her. NA-A stated R3 was always incontinent now. NA-A indicated toileting was offered every 2-3 hours to everybody that needs it. During an interview on 12/30/15, at 10:30 a.m. assistant director of nursing/licensed practical nurse (LPN)-B indicated residents are not assessed for a toileting plan or schedule and stated, "We don't have toileting programs here, we just offer every 2 hours." LPN-B stated not being sure why there had been an increase in incontinence post hospitalization for R3. In response to the question, "If the resident is wet at every two hour interval, then what do you do?" LPN-B stated, "Then they would change her." During an interview on 12/30/15, at 1:48 p.m. administrator (also a registered nurse) explained the process for developing an individualized toileting plan/schedule. Administrator stated, "Everybody should not have the same toileting plan or schedule, they should be specific to her needs." Stated, the schedule should be in their care plan. Facility policy Bowel and Bladder Assessment last revised 3/07 does not meet current standards of practice for development, care planning, and implementation of individualized toileting plan to improve, maintain, or prevent increase in urinary incontinence. R6 was identified by the facility as always incontinent of bladder although the facility lacked care plan interventions that included an individualized toileting schedule. R6 was admitted to the facility 4/22/14, with diagnosis that included diabetes mellitus according to facility record of admission.	F 279		

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The facility identified R6 on the significant change Minimum Data Set (MDS), an assessment dated 10/21/15, to require extensive assistance of two staff for toileting, was always incontinent, and had no toileting program.

Document review of R6's urinary assessment dated 10/29/15, revealed R6 was always incontinent of urine and had no trial of a toileting program.

Document review of R6's care plan dated 8/26/14, revealed a problem of urinary incontinence related to diabetes sensory deficit. Approaches included use absorbent product, encourage fluid intake, cleanse perineal area and apply barrier cream. Care plan dated 12/24/15, revealed a problem of need to maintain activities of daily living. Approaches included required extensive assist of one to two staff for toileting, provide perineal care, and use incontinent brief.

During interview on 12/29/15, at 9:09 a.m., nursing assistant (NA)-B stated had just completed R6's morning cares which included perineal care after changing incontinent brief, which was soiled with a large amount of urine. NA-B stated R6 was toileted and voided on the toilet at that time. NA-B stated R6 was incontinent day and night, wore incontinent briefs, and received perineal care after incontinent episodes. NA-B stated R6 was on a toilet schedule of every two hours, incontinent brief was always wet, and was sometimes wet in between two hour checks.

During interview on 12/30/15, at 2:30 p.m., administrator stated toileting every two hours were verbal instructions from the nurse. Administrator stated she expected an

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F 279	Continued From page 19 individualized toilet schedule to be on the care plan. During interview on 12/31/15, at 9:04 a.m., administrator verified R6's care plan lacked staff directions for toilet schedule. Although requested, no care plan policies were available. LACK OF SAFETY PRECAUTIONS WHEN TAKING A BLOOD THINNER AND CARDIAC MEDICATION: R23 received anticoagulation medication without care plan interventions to direct staff in measures to minimize the risk for bruising. R23 had diagnosis that included chronic ischemic heart disease, peripheral vascular disease, chronic atrial fibrillation, and hypertension according to provider orders dated 12/2/15. The facility identified R23 on the significant change Minimum Data Set (MDS), an assessment dated 10/26/15, to receive anticoagulant medication. R23's current signed physician orders dated 12/23/15, revealed physician orders for the anticoagulant medication, Coumadin, 2 milligrams on Monday and Friday, and 1.5 milligrams the other five days. Document review of facility medication administration record revealed R23 received Coumadin daily from 10/19/15 to 10/31/15; daily 11/1/15-11/17/15, 11/21/15-11/30/15; and 12/1/15-12/12/15, 12/14/15-12/29/15.	F 279		

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Document review of R23's care plan revealed the care plan failed to identify use of coumadin, potential risk for bleeding/bruising, and did not direct staff of interventions to minimize the risk of coumadin use.

During interview on 12/31/15, at 9:04 a.m., administrator verified R23's care plan lacked staff direction for use of coumadin and interventions to minimize the risk of bleeding/bruising. Administrator stated she expected staff instructions for use of coumadin to be included in R23's care plan.

R23 received digoxin, a medication to control heart rate, without care plan interventions to direct staff in use of digoxin.

R23 had diagnosis that included chronic ischemic heart disease, peripheral vascular disease, chronic atrial fibrillation, and hypertension according to provider orders dated 12/2/15.

R23's current provider orders, signed physician orders, dated 12/2/15, revealed physician orders for digoxin 125 micrograms daily and hold the medication if pulse is less than 50. Order start date was 10/19/15.

Document review of facility medication administration record revealed R23 received digoxin daily as ordered from 10/20/15 to 10/31/15; daily 11/1/15-11/30/15; and daily 12/1/15-12/30/15.

Document review of R23's care plan revealed the care plan failed to identify use of digoxin, and did

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not direct staff of interventions to hold the medication if pulse below 50 beats per minute.

Document review of facility undated, untitled statement regarding R23, which indicated nurse checked pulse before administration of digoxin and if pulse less than 50, nurse would select blue button at top of computer screen and type in reason digoxin was not administered.

During interview on 12/30/15, at 3:20 p.m., licensed practical nurse (LPN)-A stated, "Would hope nurses were checking the pulse." LPN-A verified the facility lacked documented evidence of daily pulse checks before administration of digoxin. LPN-A stated if pulse below 50, then would not administer digoxin and computer system would open an area to document why the medication was not given.

Document review of facility monitoring R23's vital signs from 10/7/15 to 12/30/15, revealed pulses were checked at varying hours mornings and afternoons, were not checked daily, and pulses ranged from 53 to 134.

During interview on 12/31/15, at 9:04 a.m., administrator verified digoxin instructions to monitor pulse were not identified in R23's care plan. Administrator stated she expected staff instructions for use of digoxin to be included in R23's care plan. Administrator verified the pulse monitoring provided was not daily pulse checks before administration of digoxin.

During interview on 12/31/15, at 12:40 p.m., LPN-A verified the facility lacked policies related to developing care plans.

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 to provide limited assist of 1 staff and supervision, during meal time for 1 of 1 resident (R24) during a dining observation, in addition the facility failed to follow the care plan for personal hygiene for 1 of 1 resident (R5) observed to have soiled fingernails. Findings Include: LACK OF ASSISTANCE FOR MEALS: R24's care plan dated 9/22/15 indicated R24 required limited assist of one staff for eating at times, but at least supervision, with cues to keep on task. R24's quarterly Minimum Data Set (MDS) dated 12/8/15, revealed R24 had a brief interview for mental status score of 0, which indicated severely impaired cognition, R24 required limited assist of one for eating and identified a diagnoses of Alzheimer's disease. R24's nurse progress noted dated 12/8/15 indicated, "Eating. Requires one aide for assist for eating to feed resident for all meals eating	F 282	1. R 24's care plan was revised to accurately show the level of assistance for eating. Staff were re-educated on R5's hygiene needs after meals. 2. All residents care plans were reviewed for eating assistance and hygiene needs and updated as appropriate. 3. Staff were educated on the importance of following assignment sheets/kardex for follow through on residents care plans. 4. DON/Designee will perform audits weekly for one month, then once a month for three months, and then quarterly for one year. Reports will be given to QAA on a quarterly basis.	2/9/16

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	245464	A. BUILDING _____ B. WING _____	12/31/2015

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 282	Continued From page 23 ability has decreased. Usually eats 75%, has good appetite, no eating concerns or swallowing problems." On 12/30/2015 at 9:09 a.m., R24 was observed to be in the dining room with licensed practical nurse (LPN)-C sitting by R24 assisting her to eat her breakfast. At 9:26 a.m., the telephone hanging on the dining room wall rang, LPN-C left R24 sitting at the table to answer the phone and then left the dining room. LPN-C returned to the dining room at 9:28 a.m. walked over to R24 and asked if she would like another bite and proceeded to leave R24 at the dining room table and walk to the medication cart, positioned right outside of the dining room. At 9:30 a.m. LPN-C came back into the dining room, walked around, R24 was independently drinking a beverage at this time. At 9:31 a.m. LPN-C walked to her medication cart positioned right outside of the dining room. At 9:31 a.m. LPN-C reentered the dining room and sat down by R24 and offered to assist her to eat more food. R24 accepted a bite of sausage and a drink of apple juice. LPN-C attempted to provide resident another bite and R24 turned her head away. LPN-C encouraged R24 to drink more of her fluids. R24 accepted drinks of her milk. LPN-C offered another bite of her sausage and R24 accepted the bite of food. LPN-C offered R24 a drink of her juice and R24 took the cup and started to independently drink her juice. LPN-C got the attention of a surveyor asked if the surveyor had time to watch a medication pass. LPN-C left R24 sitting at the table with her plate of food and three beverage glasses sitting in front of her. R24 moved the plate around on the table and placed food in one of the cups. There was no staff member present in the dining room at this time. LPN-C was at the	F 282		

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medication cart outside of the dining room, preparing medications for another resident. R24 picked up pieces of her food and placed them back down on her plate appearing to be playing with the food, R24 picked up a piece of her sausage and placed it in her mouth. There is no staff member present in the dining room at this time. At 9:42 a.m. LPN-C reentered the dining room to administer another resident their medication. R24 continued to pick up the food off of her plate and place it back down on her plate. At 9:44 a.m. LPN- C again left the dining room to go to the medication cart and there was no staff in the dining room. R24 started to fold the bottom of her clothing protector on top of the dining room table as it was still fastened around her neck. At 9:45 a.m. LPN-C sat back down by R24 and LPN-C used a fork to remove food from one of the cups and started offering R24 drinks of milk and offered her another bite of her sandwich. R24 accepted the bite of the food. Offered resident drink of milk and R24 accepted another bite of food. R24 picked up a piece of the grilled cheese and took a bite independently. R24 accepted another bite of grilled cheese from the nurse and accepted a drink of milk. At 9:51 a.m. R24 accepted another bite of her grilled cheese sandwich. R24 picked up one of her cups and took a drink independently. R24 accepted another bite of food at 9:52 a.m., 9:53 a.m. and 9:55 a.m. LPN-C asked R24 if she would like a cookie. LPN-C knocked on the kitchen door and asked for a soft cookie for R24. LPN-C unwrapped the cookie from the plastic bag and sat the plastic wrapper on the table. LPN-C proceed to clean a table top in the dining room. At 10:01 a.m. LPN-C walked back over to R24, asked her how the cookie was, removed her plate of food, the plastic cookie wrapper threw them in

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the garbage, left the dining room and at the medication cart. At 10:03 a.m. LPN-C reentered the dining room and asked R24 if she was done. At 10:06 a.m. LPN-C wheeled R24 out of the dining room to the day room.

On 12/31/2015 at 9:19 a.m. LPN-B stated R24 was to receive assist of one to eat.
LPN-A stated R24 was able to hold her own glass independently drink and was able to eat finger food independently. LPN-B stated her care plan indicated for meal time R24 required assist of 1 at times, but at least supervision with cues. LPN-B stated her expectation was staff should sit with R24 until she completed her meal. LPN-B verified staff did not following the care plan to provide assist of 1 during meal times and supervision with cues during the meal observed.

LACK OF PROVIDING GROOMING WHEN NEEDED:

R5's care plan dated 4/16/15 indicated R5 had macular degeneration and required supervision with grooming with a goal for R5 to be well groomed. R5's quarterly Minimum Data Set (MDS) dated 10/26/15, identified R5 required extensive assist of one person for personal hygiene and identified moderately impaired vision.

On 12/29/2015 at 6:24 p.m., R5 was observed to be sitting at dining room table drinking her beverages from her evening meal. She was observed to have brown debris underneath four fingers on her left and right hands.

On 12/29/2015 at 6:27 p.m., R5 stated staff took

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F 282	Continued From page 26 care of her fingernails once a week on her bath day and stated she was blind and has a hard time seeing. On 12/30/2015 at 1:55 p.m., NA-C stated residents' nails were cut and cleaned on their bath days. NA-C stated if staff noticed a resident had dirty nails staff cleaned them as needed. NA-C was asked to observe R5's fingernails with the surveyor. NA-C stated hers are, "Probably disgusting, they are every day." NA-C stated R5 used her fingers to eat and stated she will get food underneath her fingernails. NA-C stated some of R5's nails were so curved it can be hard to get underneath her nails to clean them. On 12/30/2015 at 2:12 p.m., during an observation with NA-C, R5 was observed to have brown debris under her fingernails on both hands. NA-C stated R5's fingernails were, "Yucky and needed to be cleaned." NA-C stated she was going to ask one of the evening shift girls to clean them tonight. On 12/30/2015 at 2:13 p.m., LPN-B verified through an observation R5 had brown debris underneath "the majority of her nails." LPN-B stated the condition of her nails was not acceptable and verified they needed to be clean. LPN-B stated staff needed to clean R5's nails and wash her hands after meals and inspect her finger nails to ensure they were clean. LPN-B verified R5's care plan did not specifically address nail care, but stated she would consider nail care to be a part of resident grooming. LPN-B verified R5's care plan was not followed for R5 to appear well groomed. A care plan policy was requested and was not provided.	F 282		

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 clean nails for 1 of 3 residents (R5) reviewed for activities of daily living. Finding Include: R5's quarterly Minimum Data Set (MDS) dated 10/26/15, identified R5 required extensive assist of one person for personal hygiene and identified moderately impaired vision. The care plan dated 4/16/15 indicated R5 had macular degeneration and required supervision with grooming. On 12/29/2015 at 6:24 p.m., R5 was observed to be sitting at dining room table drinking her beverages from her evening meal. She was observed to have brown debris underneath four fingers on her left and right hands. On 12/29/2015 at 6:27 p.m., R5 stated staff took care of her fingernails once a week on her bath day and stated she was blind and has a hard time seeing. On 12/30/2015 at 1:55 p.m., NA-C stated residents' nails were cut and cleaned on their bath days. NA-C stated if staff noticed a resident	F 312	1. R5's ADLs were addressed and updated and staff were made aware of the importance of hand hygiene throughout the day. 2. All ADLs were reviewed and updated as appropriate on all residents. 3. Education will be provided to all staff upon hire, yearly, and as deemed necessary through audit review on ADL importance. 4. DON/Designee will complete audits on a weekly basis times one month, monthly times three months, and then quarterly times one year. Reports given at QAA Meeting on a quarterly basis.	2/9/16

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had dirty nails staff cleaned them as needed. NA-C was asked to observe R5's fingernails with the surveyor. NA-C stated hers are, "Probably disgusting they are every day." NA-C stated R5 used her fingers to eat and stated she would get food underneath her fingernails. NA-C stated some of R5's nails were so curved it was hard to get underneath her nails to clean them. On 12/30/2015 at 2:12 p.m., during an observation with nursing assistant (NA)-C, R5 was observed to have brown debris under her fingernails on both hands. NA-C stated R5's fingernails were, "Yucky and needed to be cleaned." NA-C stated she was going to ask one of the evening shift girls to clean them tonight.

On 12/30/2015 at 2:13 p.m., licensed practical nurse (LPN)-B verified through an observation R5 had brown debris underneath, "the majority of her nails." LPN-B stated the condition of her nails was not acceptable and verified they needed to be clean. LPN-B stated staff needed to clean R5's nails and wash her hands after meals and inspect her finger nails to ensure they were clean. LPN-B verified R5's care plan did not specifically address nail care, but stated she would consider nail care to be a part of resident grooming. LPN-B verified R5's care plan was not followed for R5 to appear well groomed.

On 12/30/2015 at 3:29 p.m., the administrator stated she expected resident's finger nails to be maintained and cleaned. The administrator stated staff should be washing residents hand and ensuring clean fingernails daily.

A policy was requested on ensuring personal hygiene for residents and was not provided.

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F 315	Continued From page 29	F 315		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to evaluate and implement an individualized toileting plan after an increase in urinary incontinence for 1 of 2 residents (R3) reviewed for urinary incontinence. Findings include: R3 was hospitalized from 9/2/15 to 9/8/15 following a fall with femur fracture resulting in decrease of mobility and an increase in staff assistance for toileting. Following hospitalization, R3's urinary incontinence increased from frequently incontinent to always incontinent. However, the facility failed to assess the increase in urinary incontinence and develop an individualized toileting plan in an attempt to restore bladder function to the previous level or the highest attainable level of bladder function. R3's significant change Minimum Data Set dated 8/18/15 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 14, required extensive assist from one staff member for toileting, did not have a toileting	F 315	1. A toileting program evaluation will be completed on Resident 3. 2. A review of all other residents in the facility will be completed and an assessment of their toileting program will be completed. Each resident who requires a toileting program will have their individualized program implemented. 3. An assessment will be completed on admission, quarterly, and with a significant change to assure that an up-to-date toileting program is completed and care planned. 4. DON/Designee will do weekly audits for review of toileting program evaluations, then monthly audits will be completed for three months and then quarterly thereafter. Reports will be given at QAA Meeting on a quarterly basis.	2/9/16

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program, and was occasionally incontinent of urine.
R3's Significant change MDS dated 9/15/15 indicated no cognitive impairment with a BIMS score of 15, required extensive assist from two staff members for toileting, did not have a toileting program, and was frequently incontinent of urine.
R3's fourteen day MDS dated 9/22/15 indicated no cognitive impairment with a BIMS score of 15, required extensive assist from two staff members for toileting, did not have a toileting program, and was always incontinent of urine.
R3's significant change MDS dated 12/8/15 indicated no cognitive impairment with a BIMS score of 15, required extensive assist from one staff member for toileting, did not have a toilet program, and was always incontinent of urine.
The associated urinary care assessment area (CAA) indicated R3 had urge incontinence and required assistance for transferring and perineal care. The CAA included, "She is incontinent quite often but will alert staff to need to use the toilet. Incontinence products are managed by staff and pericare is completed after incontinence episodes. Will develop Care Plan."
R3's Bladder Assessment dated 12/8/15 indicated resident is usually aware of toileting needs and expresses acceptance of incontinence. Assessment further indicated R3 voided correctly, without incontinence, less than once per day and the incontinence is in small amounts. The assessment identified the type of urinary incontinence as mixed.
R3's record did not reflect an analysis or evaluation of the decline in bladder function.
R3's electronic care plan provided by the facility on 12/30/15 indicated R3 had urge incontinent and unable to reach bathroom/commode on time related to mobility deficit. The care plan directed

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staff to encourage intake, and report changes in voiding patterns or appearance in urine. The care plan did not direct staff of R3's toileting routines or needs. The indicated type of incontinence on the care plan (urge) did not reflect the assessed type of incontinence that was indicated on the bladder assessment (mixed). The record did not show evidence the care plan was revised to reflect the bladder function changes from occasionally incontinent to always incontinent.
R3's CNA Assignment Card did not reference an individualized toileting schedule or plan.
R3's voiding documentation was reviewed form 10/1/15 through 12/30/15. The documentation reflected always incontinent of urine.
R3's record did not reflect a comprehensive reassessment for an individualized toileting schedule or plan after return from hospital.
During an interview on 12/30/15, at 9:51 a.m. nursing assistant (NA)-A indicated R3 used to put on her call light prior to her fall to use the restroom. NA-A explained R3 didn't use the call light at all anymore to use the bathroom and calls when she is wet so we can change her. NA-A stated R3 was always incontinent now. NA-A indicated toileting was offered every 2-3 hours to everybody.
During an interview on 12/30/15, at 10:30 a.m. assistant director of nursing licensed practical nurse ADON LPN-B indicated residents are not assessed for a toileting plan or schedules and stated, "We don't have toileting programs here, we just offer every 2 hours." LPN-B stated not being sure why there had been an increase in incontinence post hospitalization. In response to the question, "If the resident is wet at every two hour interval, then what do you do? " ADON LPN-B stated, "Then they would change her."

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F 315	Continued From page 32 During an interview on 12/30/15, at 12:47 a.m. R3 stated that since she fell and broke her leg she does not ask to get up to use the bathroom anymore. R3 stated she goes to the bathroom in her pants and then calls staff to change her. R3 explained reason for intentional incontinence was out of fear of falling again and was not comfortable. R3 indicated an awareness of urge to void and has not been offered alternatives such as bedside commode or bedpan. During an interview on 12/30/15, at 1:07 p.m. NA-B stated R3 was more incontinent than prior to fall and explained R3 does not want to go to the toilet at all, she refuses. NA-B did not know the reason for refusals. NA-B explained R3 could walk and use a walker but R3 would rather have staff lift and put her on the toilet. NA-B indicated R3 was not on a toileting schedule and was not aware of any interventions to decrease the amount of urinary incontinence. During an interview on 12/30/15, at 1:48 p.m. administrator (also a registered nurse) explained the process for developing an individualized toileting plan/schedule. Administrator stated, "Everybody should not have the same toileting plan or schedule, they should be specific to her needs." Stated, the schedule should be in the care plan. Facility policy Bowel and Bladder Assessment last revised 3/07 does not meet current standards of practice for development, care planning, and implementation of individualized toileting plan to improve, maintain, or prevent increase in urinary incontinence.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		1/11/16

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F 371	Continued From page 33 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 dietary low temperature/chemical sanitation dishwasher maintained water temperatures of 120 degrees for wash and rinse cycles. This had the potential to affect all 19 residents residing in the facility, staff and visitors who utilized dietary dishes. Findings include: During the initial kitchen tour on 12/28/15, at 8:45 a.m., dietary aide (DA)-A washed a load of dishes in the dishwasher. At that time, DA-A checked the dishwasher wash cycle temperature on the dishwasher dial, which read 102 degrees, and checked the rinse cycle on the dial, which read 105 degrees. DA-A used a chlorine test paper strip to monitor chemicals which read 100 parts per million (ppm). Dishwasher logs for 12/1/15 to 12/28/15, were reviewed, which revealed dishwasher rinse cycle temperatures 100-120 degrees. During interview at that time, dietary manager verified the temperatures recorded on the facility dishwasher temperature log were the rinse cycle temperatures. Dietary manager stated she was aware of the low dishwasher temperatures. Dietary manager stated she had	F 371	1. A booster was purchased for the dishwasher to maintain water temperatures of 120 degrees for wash and rinse cycles. 2. It was installed on 1/11/16. 3. Temperatures will be monitored during each meal time wash and documented. 4. Dietary manager will review documented temperatures on her scheduled days of work.	

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reported the low temperatures to administration several times. Dietary manager stated she expected the dishwasher wash temperature to be 130 degrees and the rinse temperature to be 120 degrees. Dietary manager verified the dishwasher was a low temperature dishwasher.

During observations on 12/28/15, at 10:25 a.m., dietary manager ran one dishwasher cycle and then checked water temperatures on the second cycle, with wash 105 degrees and rinse 105 degrees. During interview at that time, dietary manager stated had first noticed low dishwasher temperatures, possibly in 9/2015, when maintenance department lowered water temperatures in resident rooms. During interview at that time, dietary manager verified the chemical solution used in the dishwasher was Ecolab Ultra San, liquid sanitizer for low temperature machines.

During interview on 12/28/15, at 10:35 a.m., dietary manager verified 8/16/15, dishwasher rinse temperature was 135 degrees and verified the temperatures had been 120 and below since 8/16/15.

Facility Dishwasher Temperatures and PPM (parts per million) Levels logs were reviewed for 8/16/15 through 12/28/15. Dishwasher rinse temperatures and PPM chemical test strips were checked one to three times daily with the following identified:
8/16/15-breakfast 135 degrees, PPM-100.
8/17/15-breakfast 112 degrees, PPM-100; lunch-120 degrees, PPM-100.
308 rinse temperatures were recorded with 82 recordings at 120 degrees,and 226 rinse recordings were 100 to 115 degrees.

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	245464	A. BUILDING _____ B. WING _____	12/31/2015

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 371	Continued From page 35 Observations on 12/28/15, at 11:20 a.m., revealed signage on the dishwasher with the following information: Ecolab--minimum wash--120 degrees; minimum rinse--120 degrees. The signage temperatures were verified by DA-A and dietary manager. During interview at that time, dietary manager verified no documented evidence of notifying administration of low dishwasher temperatures. During interview on 12/28/15, at 11:22 a.m., administrator verified she was aware of the low dishwasher temperatures. During interview on 12/28/15, at 11:43 a.m., director of nursing stated facility had no gastroenteritis symptoms since 8/16/15. Document review of manufacturer's instructions for the dishwasher provided by facility, revealed the following directions: operating temperatures-wash (minimum) 120 degrees Fahrenheit and ; sanitizing rinse (min) 120 degrees Fahrenheit. Document review of facility "Dishwashing and Equipment" policy dated 10/18/11, revealed the following: #5." The wash water temperature shall be within 120-140 degrees;" #6. "The sanitizing ratio shall be within 50-100."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425		2/9/16

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F 425	Continued From page 36 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure LPN-C was qualified to administer medications through a peripherally inserted central catheter (PICC), resulting in incorrect technique of medication administration for 1 of 1 residents (R17) who had a PICC line, in addition the facility failed to ensure an open multi-dose vial of influenza vaccinations was appropriately discarded after the medication had expired. This had the potential to effect new admissions requesting the influenza vaccination. Findings include LACK OF TRAINING TO ADMINISTER ANTIBIOTICS THROUGH A PICC LINE: R17 was observed to receive IV antibiotic from license practical nurse (LPN)-C on 12/31/15 at 10:15 a.m. via PICC line. R17's PICC line was located on the right upper arm. LPN-C washed	F 425	1. Staff were educated on correct IV protocol. Out dated medication was pulled and destroyed. 2. There were no other residents at this time on IVs. Upon admission of an IV resident, the policy will be reviewed by all nursing staff prior to administration of IV. Pharmacy consultant and nursing administration will monitor for outdated medications and remove and destroy. 3. Annual and upon admission of IV (PICC Line) resident, education will be completed by licensed staff. Monthly review of medication expiration dates will be done by pharmacy consultant and nursing administration. 4. Education criteria will be updated as needed for all procedures prior to	

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F 425	Continued From page 37 hands and donned gloves. LPN-C explained to R17 the medication was going to be administered. LPN-C then removed the locking blunt tip cannula from the sterile package, removed the sterile cap from the cannula, and then rubbed an alcohol swab on the sterile end. LPN-C did not perform sterilization of the PICC injection cap as required to prevent infections. The other end of the locking cannula was open. LPN-C then removed the 10 cubic centimeter (cc) normal saline flush syringe from the wrapper, removed the sterile cap, and then rubbed an alcohol swab on the sterile end. LPN-C then connected the saline flush to the blunt tip cannula and turned it to lock it into place. LPN-C pushed down on the syringe plunger with thumb quite forcefully and very quickly infused the 10 cc's of saline in all one pushing motion. LPN-C did not check the PICC line for placement. LPN-C then removed the saline flush syringe, uncapped the antibiotic ball (type uses positive pressure to infuse medication without a pump), and connected the antibiotic into the same blunt tip locking cannula that was used for the saline flush. LPN-C then took off her gloves and washed hands. During an interview with LPN-C directly following the observation, LPN-C was not able to depict what parts of the procedure that were performed incorrectly during the infusion procedure. LPN-C indicated the procedure was performed the way it was taught to her many years ago. During an interview on 12/31/15, at 10:53 a.m. LPN-B/assistant director of nursing stated LPN's were allowed to administer PICC line medications and education was completed annually. LPN-B was asked to provide proof of the required completed education for all the licensed practical nurses. LPN-B indicated on a hand written note	F 425	education of staff. Monthly audits of medication expiration dates will be done for a year.	

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F 425	Continued From page 38	F 425		

addressed to the surveyor; the director of nursing (DON) and herself had completed the training course and there were no PICC training dates on file for the LPN's in the facility.
During an interview on 12/31/15, at approximately 11:30 a.m. administrator (also a registered nurse) indicated LPN's are required to complete education for intravenous infusion. After explaining the technique LPN-C used, the Administrator indicated the procedure was not performed correctly.
During an interview on 1/8/15, at 1:22 p.m. with infusion specialist registered nurse (RN)-A from the hospital where the PICC line was inserted stated the injection cap has to be cleaned with an alcohol swab or other approved disinfectant for at least 15 seconds. RN-A stated, saline syringe and blunt tip cannula should not be cleaned with alcohol, as they are sterile. RN-A stated the blunt tip cannula cannot be reused and it has to be changed after every use for infection control purposes. RN-A stated placement has to be checked every time medication is infused into the PICC line to ensure the line is where it's supposed to be and avoid the build-up of a sheath that can form at the catheter end. RN-A stated failure to do so could potentially lead to serious health consequences and serious infections. RN-A stated placement is checked by always infusing 10 cc's of normal saline then drawing back on the plunger to aspirate 5-6 cc's of blood, then the line flushed with another 10 cc's of normal saline, then the medication can be infused. RN-A explained when flushing a PICC line you should never force the flush, the flush should be administered slowly and with a push, stop, push, stop method until the syringe is empty. RN-A stated the expectation for follow-up care for their patients at outside agencies is to

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follow the above guidelines and the PICCs are managed by trained staff nurses.
The facility provided the policy Limited Intravenous Therapy Procedures for Qualified Licensed Practical Nurses (with IV Course). The policy included, "The Licensed Practical Nurse, who has certification from the Minnesota Board of Nursing verifying the successful completion of a course in intravenous therapy, may perform limited intravenous therapy procedures on adult patients."
The facility provided a MED-PASS, inc. procedure Catheter Insertion and Care on 1/7/15 after the survey exit date. The policy directed staff to, "Consult State Nurse Practice Act for RN/LPN scope of practice and functions.", as general guidelines. The policy included the flushing technique that directed staff to use a push-pause or pulsing motion for flushing technique. Aspirate the catheter for blood return to confirm patency prior to administration of medications and solutions. The complications listed in the policy included the warning in all capitol letters "IF RESISTANCE OR LACK OF BLOOD RETURN ARISE AT ANY TIME DURING FLUSHING STOP THE FLUSH AND CONSULT IV NURSE SPECIALIST OR PHYSICIAN."
INFLUENZA VACCINATION WAS NOT REMOVED AFTER EXPIRATION DATE:
The medication storage review conducted on 12/29/15 at 1:20 p.m. with LPN-C. revealed an open multi-dose vial of Fluzone high-dose (influenza vaccination) with an open date of 11/7/15. LPN-C stated the shelf life after opening the vaccination was good for 30 days and the vial discarded.
During an interview on 12/29/15, at 1:49 p.m. director of nursing (DON) indicated the influenza vaccine should have been discarded and stated,

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F 425	Continued From page 40 "We don't have a set system to check for outdated medication in the refrigerator, the expectation is the nurses are checking for dates on the vial prior to administration." During an interview 1/4/15, at 12:10 p.m. pharmacist-A stated, "once a multi-dose vial of influenza vaccination is opened, it is only good for 30 days. The rest needs to be discarded." Facility policy and procedure used for Medication Ordering and Receiving from Pharmacy with a last revision date of 8/2014 instructed the immediate removal and disposal of medications that are outdated, storage conditions are monitored monthly or per facility policy, multi-dose vials requires an expiration date shorter than manufacturer's recommendations to insure medication purity and potency. The procedure directed staff to put a "date opened" sticker on the multi-dose vial with an expiration date not to exceed 30 days unless directed by manufacturer. The policy then directed staff to check expiration date prior to administration and "all expired medication will be removed from the active supply and destroyed in the facility, regardless of amount remaining."	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		2/9/16

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F 441	Continued From page 41 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a multi-use glucometer was correctly disinfected according to the manufacturer's recommendations for disinfecting re-usable equipment this had the potential to effect 1 of 10 residents (R7) who used the same glucometer for checking blood sugars. Findings include: R7 was observed on 12/20/15 at 11:50 a.m. when licensed practical nurse (LPN)-C washed hands,	F 441	1. Education will be provided to all licensed staff regarding the sanitation of glucometers. 2. Meters will be given to each diabetic that has blood glucose checks. 3. Upon admission, any resident who is a diabetic will have a glucometer assigned to them for their stay. 4. Audits will be completed on a spot check basis at least weekly, as well as,	

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F 441	Continued From page 42 donned gloves, and obtained a blood sugar reading from R7 using a multi-use glucometer. Following the procedure LPN-C returned to the medication cart, rubbed a PDI Super Sani-Cloth Germicidal Disposable Wipe on the glucometer thoroughly for approximately five seconds, and placed the glucometer on the medication cart where it air dried within seconds. During an interview with LPN-C directly following the procedure, LPN-C stated an unawareness of the manufacturer's direction on the container the equipment needed to be continuously wet for two full minutes for optimal disinfectants effectiveness. Manufacturer's instruction on the container for disinfecting included, allow treated surface to remain wet for two minutes and use additional wipes to assure surfaces have the continuous full two minute contact time. Facility procedure Glucometer Cleaning and Disinfecting (not dated) indicated, "All glucometers must be cleaned after each patient use, in between patients, and after contact with blood or body fluids. Wipe down with Sani-Coths (purple top)-CONTACT TIME for purple wipes is 2 minutes."	F 441	monthly basis to assure compliance with this process for three months and then quarterly for a year. Reports will be given to a the QAA Committee on a quarterly basis.	
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced	F 492		2/9/16

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F 492	Continued From page 43 by: Based on interview and document review, the facility failed to implement the appeals process for 1 of 1 resident (R20) who requested review of the facility's determination to discontinue Medicare part A services. Findings include: R20 was given a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) notice on 12/2/2015 that Medicare A covered skilled services were ending on 12/4/2015. R20 requested an appeal of this determination to be submitted to Medicare for further review. It was signed by the resident. There was no indication that the facility had submitted this appeal to Medicare. When interviewed on 12/31/15 at 9:33 a.m., the business office manager (BOM) stated that she had absolutely no discussion with the resident's daughter regarding a demand bill. She stated that the Director of Nursing (DON) had the resident sign the form. The BOM stated that she was not told by the DON that R20 had requested a demand bill. The BOM stated that she was not aware that R20 had requested this to be done. When interviewed on 12/31/15 at 10:20 a.m., the administrator stated that if a resident was going to be potentially discontinued from therapy services, first, nursing staff would meet with therapy and the resident to determine if the resident required any further therapy. The administrator stated that if a resident had requested an appeal of the determination be submitted to Medicare, then the business office manager would have been notified.	F 492	1. Our process and procedures for demand billing was reviewed for resident R 20. R20 did not want to have a demand bill done nor did R20 want further services. This area was checked in error. 2. A review of our other denials was completed. Education will be provided to all individuals working with the Medicare A Denial process. 3. The policy and procedure will be reviewed and undated to current requirements. 4. Audits will be done by nursing and billing of denials of Medicare A on a monthly basis for three months and then quarterly for one year. Reports will be provided at QAA Meeting on a quarterly basis.	

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F 492	Continued From page 44 When a policy was requested for demand bill policy and procedure, the facility provided a document titled, Medicare Claims Processing Manual: chapter 30- financial liability protections. It contained no language which directed the facility when a resident requested an appeal submitted to Medicare for further review.	F 492		

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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	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/26/2016

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto: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 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(111) construction. The facility is fully sprinklered since 1/4/2013. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 25 beds and had a census of 20 beds at the time of the survey.	K 000		

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K 000	Continued From page 2	K 000		
K 038 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d) and the 2007 MN State Fire Code, Appendix I. Findings include: On facility tour between 10:00 AM and 12:00 PM on 12/30/2015 , observation revealed that the Secondary Exit from the lower level needs to be repaired and/or replaced. Presently, an excessive amount of force is required to push on the door for it to open. This deficient practice was confirmed by the Facility Maintenance Director (Ethan) at the time of discovery.	K 038	A new door was purchased and arrived on 1/26/16. It will be installed prior to 2/9/16.	2/9/16
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		1/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/30/2015**

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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K 062 SS=D	Continued From page 3 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 documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 25 residents. Findings include: On 12/30/2015, at 10:30 AM, observation revealed: 1. A review of documentation and interview with the Chief Building Engineer , revealed the facility failed to provide documentation of the quarterly fire sprinkler flow tests inspections required by NFPA 13(99) and NFPA 25(98). This finding was confirmed with the Chief Building Engineer (Ethan) at the time of discovery.	K 062	Fire sprinkler flow test inspections will be completed as required by NFPA 13 (99) and NFPA 25(98). They will be documented in a log book.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		1/30/16

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	245464	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/30/2015**

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K 144	Continued From page 4 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 25 residents. Findings include: On facility tour between 10:00 AM and 12:00 PM on 12/30/2015, documentation review of the weekly inspection logs for the emergency generator revealed that the weekly operational inspection were missed for the period of July 06, 2015 to July 31, 2015. This deficient practice was confirmed by the Facility Maintenance Director (Ethan) at the time of discovery.	K 144	The emergency generator inspection will be completed weekly as directed by the NFPA regulations.	

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
January 20, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5464027

Dear Ms. Rauk:

The above facility was surveyed on December 28, 2015 through December 31, 2015 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, Health Regulation 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.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should 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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00922	A. BUILDING: _____ B. WING _____	12/31/2015

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 28, 29, 30, & 31, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		2/9/16

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure all newly employed staff completed Alzheimer's/dementia training and failed to provide a description of the facilities dementia program to consumers in either written or electronic form. Findings include: During an interview on 12/31/15, at 12:02 p.m. the administrator stated, "to my knowledge we don't have a notification letter." The administrator was unable to produce completed dementia training for employees hired in the last year and indicated there were no training dates on file. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all staff receive Alzheimer's training. The Director of Nursing or designee could draft a means of consumer notification to be given at time of admission to residents and family members. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 302	Will comply.	
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and	2 435		2/9/16

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2 435	Continued From page 4 procedures must include the following: A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to give appropriate notice of incoming roommates for 1 of 1 resident (R13) who received two new roommates. Findings Include: R13 was interviewed on 12/29/15 at 2:32 p.m., R13 indicated she had roommate changes and had not been notified previously of getting a roommate. On 12/30/2015 at 11:01 a.m. the activity/social services director (ASSD) stated she was aware R13 had a roommate move into her room in September 2015 when her current roommate moved in. The ASSD stated she did not document roommate change notifications and was not sure if another staff member did. The ASSC stated she was not involved in the process of notifying a resident they were getting a new roommate. The ASDD stated she could not confirm or deny whether residents were getting informed of new roommates as she was not responsible at this time for informing them. On 12/30/2015 at 2:21 p.m., licensed practical nurse (LPN)-B stated normally if a resident was going to get a new roommate we let the resident	2 435	Will comply.	

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2 435	Continued From page 5 and family know. LPN-B stated the notification would be documented under the social services progress notes. On 12/30/2015 at 3:27 p.m., the administrator stated residents should be notified they are getting a new roommate prior to the resident moving in. The administrator stated staff should document the notification in the resident's medical record. On 12/31/2015 8:48 a.m., the business office manager verified R13 had two new roommates in the year 2015. R13 had a new roommate move in on 8/3/15 and 9/30/15. A policy on notification of a new roommate was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could work with the social worker/designee to update policies and procedures for when to notify the resident(s) of room/roommate changes, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the resident(s) had been notified as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 435		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are	2 560		2/9/16

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2 560	Continued From page 6 identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions that included individualized toileting schedules for 2 of 2 residents (R3,R6) reviewed for incontinence and in addition the facility failed to develop care plan interventions for Coumadin (blood thinner medication) and digoxin (heart rate control medication) for 1 of 5 residents (R23) reviewed for unnecessary mediations. Findings include: LACK OF INDIVIDUALIZED TOILETING SCHEDULE BASED ON COMPREHENSIVE ASSESSMENT: R3 was hospitalized from 9/2/15 to 9/8/15 following a fall with femur fracture resulting in decrease of mobility and an increase in staff assistance for toileting. Following hospitalization, R3's urinary incontinence increased from frequently to always incontinent. The facility failed to develop a comprehensive urinary care plan to reflect the changes of R3's voiding habits. R3's significant change Minimum Data Set (MDS) dated 12/8/15 indicated no cognitive impairment with a Brief Interview for Mental Status score of 15. The significant change MDS dated 9/15/15 indicated no toileting program or trial, frequently incontinent of urine and required extensive assist of two staff for toileting. R3's 14 day MDS dated 9/22/15 indicated no toileting program or trial, always incontinent of urine and required extensive assist of two staff for toileting. The	2 560	Will comply.	

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2 560	Continued From page 7 significant change MDS dated 12/8/15 indicated no toileting program or trail, always incontinent of urine and required extensive assist of one staff for toileting. The associated urinary care assessment area (CAA) indicated R3 had urge incontinence and required assistance for transferring and perineal care. The CAA included, "She is incontinent quite often but will alert staff to need to use the toilet. Incontinence products are managed by staff and pericare is completed after incontinence episodes. Will develop Care Plan." Facility Bladder assessment dated 12/8/15 indicated resident is usually aware of toileting needs and expresses acceptance of incontinence. Assessment further indicated R3 voided correctly, without incontinence, less than once per day and the incontinence is in small amounts. The assessment identified the type of urinary incontinence as mixed. R3's electronic care plan provided by the facility on 12/30/15 indicated R3 had urge incontinent and unable to reach bathroom/commode in time related to mobility deficit. The care plan directed staff to encourage intake, and report changes in voiding patterns or appearance in urine. The care plan did not direct staff of R3's toileting routines or needs. The care plan did not reflect the assessed type of incontinence (mixed). R3's CNA Assignment Card did not reference an individualized toileting schedule or plan. R3's voiding diary was reviewed form 10/1/15 through 12/30/15. The diary reflected always incontinent of urine. During an interview on 12/30/15, at 9:51 a.m. nursing assistant (NA)-A indicated R3 used to put on her call light prior to her fall to use the restroom. NA-A explained R3 didn't use the call light at all anymore to use the bathroom and calls when she is wet so we can change her. NA-A stated R3 was always incontinent now. NA-A	2 560		

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2 560	Continued From page 8 indicated toileting was offered every 2-3 hours to everybody that needs it. During an interview on 12/30/15, at 10:30 a.m. assistant director of nursing/licensed practical nurse (LPN)-B indicated residents are not assessed for a toileting plan or schedule and stated, "We don't have toileting programs here, we just offer every 2 hours." LPN-B stated not being sure why there had been an increase in incontinence post hospitalization for R3. In response to the question, "If the resident is wet at every two hour interval, then what do you do?" LPN-B stated, "Then they would change her." During an interview on 12/30/15, at 1:48 p.m. administrator (also a registered nurse) explained the process for developing an individualized toileting plan/schedule. Administrator stated, "Everybody should not have the same toileting plan or schedule, they should be specific to her needs." Stated, the schedule should be in their care plan. Facility policy Bowel and Bladder Assessment last revised 3/07 does not meet current standards of practice for development, care planning, and implementation of individualized toileting plan to improve, maintain, or prevent increase in urinary incontinence. R6 was identified by the facility as always incontinent of bladder although the facility lacked care plan interventions that included an individualized toileting schedule. R6 was admitted to the facility 4/22/14, with diagnosis that included diabetes mellitus according to facility record of admission. The facility identified R6 on the significant change Minimum Data Set (MDS), an assessment dated 10/21/15, to require extensive assistance of two	2 560		

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2 560	Continued From page 9 staff for toileting, was always incontinent, and had no toileting program. Document review of R6's urinary assessment dated 10/29/15, revealed R6 was always incontinent of urine and had no trial of a toileting program. Document review of R6's care plan dated 8/26/14, revealed a problem of urinary incontinence related to diabetes sensory deficit. Approaches included use absorbent product, encourage fluid intake, cleanse perineal area and apply barrier cream. Care plan dated 12/24/15, revealed a problem of need to maintain activities of daily living. Approaches included required extensive assist of one to two staff for toileting, provide perineal care, and use incontinent brief. During interview on 12/29/15, at 9:09 a.m., nursing assistant (NA)-B stated had just completed R6's morning cares which included perineal care after changing incontinent brief, which was soiled with a large amount of urine. NA-B stated R6 was toileted and voided on the toilet at that time. NA-B stated R6 was incontinent day and night, wore incontinent briefs, and received perineal care after incontinent episodes. NA-B stated R6 was on a toilet schedule of every two hours, incontinent brief was always wet, and was sometimes wet in between two hour checks. During interview on 12/30/15, at 2:30 p.m., administrator stated toileting every two hours were verbal instructions from the nurse. Administrator stated she expected an individualized toilet schedule to be on the care plan. During interview on 12/31/15, at 9:04 a.m.,	2 560		

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2 560	Continued From page 10 administrator verified R6's care plan lacked staff directions for toilet schedule. Although requested, no care plan policies were available. LACK OF SAFETY PRECAUTIONS WHEN TAKING A BLOOD THINNER AND CARDIAC MEDICATION: R23 received anticoagulation medication without care plan interventions to direct staff in measures to minimize the risk for bruising. R23 had diagnosis that included chronic ischemic heart disease, peripheral vascular disease, chronic atrial fibrillation, and hypertension according to provider orders dated 12/2/15. The facility identified R23 on the significant change Minimum Data Set (MDS), an assessment dated 10/26/15, to receive anticoagulant medication. R23's current signed physician orders dated 12/23/15, revealed physician orders for the anticoagulant medication, Coumadin, 2 milligrams on Monday and Friday, and 1.5 milligrams the other five days. Document review of facility medication administration record revealed R23 received Coumadin daily from 10/19/15 to 10/31/15; daily 11/1/15-11/17/15, 11/21/15-11/30/15; and 12/1/15-12/12/15, 12/14/15-12/29/15. Document review of R23's care plan revealed the care plan failed to identify use of coumadin, potential risk for bleeding/bruising, and did not direct staff of interventions to minimize the risk of	2 560		

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2 560	Continued From page 11 coumadin use. During interview on 12/31/15, at 9:04 a.m., administrator verified R23's care plan lacked staff direction for use of coumadin and interventions to minimize the risk of bleeding/bruising. Administrator stated she expected staff instructions for use of coumadin to be included in R23's care plan. R23 received digoxin, a medication to control heart rate, without care plan interventions to direct staff in use of digoxin. R23 had diagnosis that included chronic ischemic heart disease, peripheral vascular disease, chronic atrial fibrillation, and hypertension according to provider orders dated 12/2/15. R23's current provider orders, signed physician orders, dated 12/2/15, revealed physician orders for digoxin 125 micrograms daily and hold the medication if pulse is less than 50. Order start date was 10/19/15. Document review of facility medication administration record revealed R23 received digoxin daily as ordered from 10/20/15 to 10/31/15; daily 11/1/15-11/30/15; and daily 12/1/15-12/30/15. Document review of R23's care plan revealed the care plan failed to identify use of digoxin, and did not direct staff of interventions to hold the medication if pulse below 50 beats per minute. Document review of facility undated, untitled statement regarding R23, which indicated nurse checked pulse before administration of digoxin	2 560		

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2 560	Continued From page 12 and if pulse less than 50, nurse would select blue button at top of computer screen and type in reason digoxin was not administered. During interview on 12/30/15, at 3:20 p.m., licensed practical nurse (LPN)-A stated, "Would hope nurses were checking the pulse." LPN-A verified the facility lacked documented evidence of daily pulse checks before administration of digoxin. LPN-A stated if pulse below 50, then would not administer digoxin and computer system would open an area to document why the medication was not given. Document review of facility monitoring R23's vital signs from 10/7/15 to 12/30/15, revealed pulses were checked at varying hours mornings and afternoons, were not checked daily, and pulses ranged from 53 to 134. During interview on 12/31/15, at 9:04 a.m., administrator verified digoxin instructions to monitor pulse were not identified in R23's care plan. Administrator stated she expected staff instructions for use of digoxin to be included in R23's care plan. Administrator verified the pulse monitoring provided was not daily pulse checks before administration of digoxin. During interview on 12/31/15, at 12:40 p.m., LPN-A verified the facility lacked policies related to developing care plans. SUGGESTED METHOD OF CORRECTION: The facility could review care plan policies/procedures and revise if necessary, the facility could then develop and present education to staff members regarding importance of fully developing/revising the resident's care plan, the facility could then develop and implement an auditing system as	2 560		

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2 560	Continued From page 13 part of quality assurance program that would ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan to provide limited assist of 1 staff and supervision, during meal time for 1 of 1 resident (R24) during a dining observation, in addition the facility failed to follow the care plan for personal hygiene for 1 of 1 resident (R5) observed to have soiled fingernails. Findings Include: LACK OF ASSISTANCE FOR MEALS: R24's care plan dated 9/22/15 indicated R24 required limited assist of one staff for eating at times, but at least supervision, with cues to keep on task. R24's quarterly Minimum Data Set (MDS) dated 12/8/15, revealed R24 had a brief interview for	2 565	Will comply.	2/9/16

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2 565	Continued From page 14 mental status score of 0, which indicated severely impaired cognition, R24 required limited assist of one for eating and identified a diagnoses of Alzheimer's disease. R24's nurse progress noted dated 12/8/15 indicated, "Eating. Requires one aide for assist for eating to feed resident for all meals eating ability has decreased. Usually eats 75%, has good appetite, no eating concerns or swallowing problems." On 12/30/2015 at 9:09 a.m., R24 was observed to be in the dining room with licensed practical nurse (LPN)-C sitting by R24 assisting her to eat her breakfast. At 9:26 a.m., the telephone hanging on the dining room wall rang, LPN-C left R24 sitting at the table to answer the phone and then left the dining room. LPN-C returned to the dining room at 9:28 a.m. walked over to R24 and asked if she would like another bite and proceeded to leave R24 at the dining room table and walk to the medication cart, positioned right outside of the dining room. At 9:30 a.m. LPN-C came back into the dining room, walked around, R24 was independently drinking a beverage at this time. At 9:31 a.m. LPN-C walked to her medication cart positioned right outside of the dining room. At 9:31 a.m. LPN-C reentered the dining room and sat down by R24 and offered to assist her to eat more food. R24 accepted a bite of sausage and a drink of apple juice. LPN-C attempted to provide resident another bite and R24 turned her head away. LPN-C encouraged R24 to drink more of her fluids. R24 accepted drinks of her milk. LPN-C offered another bite of her sausage and R24 accepted the bite of food. LPN-C offered R24 a drink of her juice and R24 took the cup and started to independently drink her juice. LPN-C got the attention of a surveyor	2 565		

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2 565	Continued From page 15 asked if the surveyor had time to watch a medication pass. LPN-C left R24 sitting at the table with her plate of food and three beverage glasses sitting in front of her. R24 moved the plate around on the table and placed food in one of the cups. There was no staff member present in the dining room at this time. LPN-C was at the medication cart outside of the dining room, preparing medications for another resident. R24 picked up pieces of her food and placed them back down on her plate appearing to be playing with the food, R24 picked up a piece of her sausage and placed it in her mouth. There is no staff member present in the dining room at this time. At 9:42 a.m. LPN-C reentered the dining room to administer another resident their medication. R24 continued to pick up the food off of her plate and place it back down on her plate. At 9:44 a.m. LPN- C again left the dining room to go to the medication cart and there was no staff in the dining room. R24 started to fold the bottom of her clothing protector on top of the dining room table as it was still fastened around her neck. At 9:45 a.m. LPN-C sat back down by R24 and LPN-C used a fork to remove food from one of the cups and started offering R24 drinks of milk and offered her another bite of her sandwich. R24 accepted the bite of the food. Offered resident drink of milk and R24 accepted another bite of food. R24 picked up a piece of the grilled cheese and took a bite independently. R24 accepted another bite of grilled cheese from the nurse and accepted a drink of milk. At 9:51 a.m. R24 accepted another bite of her grilled cheese sandwich. R24 picked up one of her cups and took a drink independently. R24 accepted another bite of food at 9:52 a.m., 9:53 a.m. and 9:55 a.m. LPN-C asked R24 if she would like a cookie. LPN-C knocked on the kitchen door and asked for a soft cookie for R24. LPN-C	2 565		

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2 565	Continued From page 16 unwrapped the cookie from the plastic bag and sat the plastic wrapper on the table. LPN-C proceed to clean a table top in the dining room. At 10:01 a.m. LPN-C walked back over to R24, asked her how the cookie was, removed her plate of food, the plastic cookie wrapper threw them in the garbage, left the dining room and at the medication cart. At 10:03 a.m. LPN-C reentered the dining room and asked R24 if she was done. At 10:06 a.m. LPN-C wheeled R24 out of the dining room to the day room. On 12/31/2015 at 9:19 a.m. LPN-B stated R24 was to receive assist of one to eat. LPN-A stated R24 was able to hold her own glass independently drink and was able to eat finger food independently. LPN-B stated her care plan indicated for meal time R24 required assist of 1 at times, but at least supervision with cues. LPN-B stated her expectation was staff should sit with R24 until she completed her meal. LPN-B verified staff did not following the care plan to provide assist of 1 during meal times and supervision with cues during the meal observed. LACK OF PROVIDING GROOMING WHEN NEEDED: R5's care plan dated 4/16/15 indicated R5 had macular degeneration and required supervision with grooming with a goal for R5 to be well groomed. R5's quarterly Minimum Data Set (MDS) dated 10/26/15, identified R5 required extensive assist of one person for personal hygiene and identified moderately impaired vision. On 12/29/2015 at 6:24 p.m., R5 was observed to be sitting at dining room table drinking her	2 565		

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2 565	Continued From page 17 beverages from her evening meal. She was observed to have brown debris underneath four fingers on her left and right hands. On 12/29/2015 at 6:27 p.m., R5 stated staff took care of her fingernails once a week on her bath day and stated she was blind and has a hard time seeing. On 12/30/2015 at 1:55 p.m., NA-C stated residents' nails were cut and cleaned on their bath days. NA-C stated if staff noticed a resident had dirty nails staff cleaned them as needed. NA-C was asked to observe R5's fingernails with the surveyor. NA-C stated hers are, "Probably disgusting, they are every day." NA-C stated R5 used her fingers to eat and stated she will get food underneath her fingernails. NA-C stated some of R5's nails were so curved it can be hard to get underneath her nails to clean them. On 12/30/2015 at 2:12 p.m., during an observation with NA-C, R5 was observed to have brown debris under her fingernails on both hands. NA-C stated R5's fingernails were, "Yucky and needed to be cleaned." NA-C stated she was going to ask one of the evening shift girls to clean them tonight. On 12/30/2015 at 2:13 p.m., LPN-B verified through an observation R5 had brown debris underneath "the majority of her nails." LPN-B stated the condition of her nails was not acceptable and verified they needed to be clean. LPN-B stated staff needed to clean R5's nails and wash her hands after meals and inspect her finger nails to ensure they were clean. LPN-B verified R5's care plan did not specifically address nail care, but stated she would consider nail care to be a part of resident grooming. LPN-B verified R5's care plan was not followed for R5 to appear	2 565		

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2 565	Continued From page 18 well groomed. A care plan policy was requested and was not provided. SUGGESTED METHOD OF CORRECTION: The facility could review care plan policies/procedures and revise if necessary, the facility could then develop and present education to staff members regarding importance of following the resident's care plan, the facility could then develop and implement an auditing system as part of quality assurance program that would ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure clean nails for 1 of 3 residents (R5) reviewed for activities of daily living. Finding Include: R5's quarterly Minimum Data Set (MDS) dated	2 860	Will comply.	2/9/16

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2 860	Continued From page 19 10/26/15, identified R5 required extensive assist of one person for personal hygiene and identified moderately impaired vision. The care plan dated 4/16/15 indicated R5 had macular degeneration and required supervision with grooming. On 12/29/2015 at 6:24 p.m., R5 was observed to be sitting at dining room table drinking her beverages from her evening meal. She was observed to have brown debris underneath four fingers on her left and right hands. On 12/29/2015 at 6:27 p.m., R5 stated staff took care of her fingernails once a week on her bath day and stated she was blind and has a hard time seeing. On 12/30/2015 at 1:55 p.m., NA-C stated residents' nails were cut and cleaned on their bath days. NA-C stated if staff noticed a resident had dirty nails staff cleaned them as needed. NA-C was asked to observe R5's fingernails with the surveyor. NA-C stated hers are, "Probably disgusting they are every day." NA-C stated R5 used her fingers to eat and stated she would get food underneath her fingernails. NA-C stated some of R5's nails were so curved it was hard to get underneath her nails to clean them. On 12/30/2015 at 2:12 p.m., during an observation with nursing assistant (NA)-C, R5 was observed to have brown debris under her fingernails on both hands. NA-C stated R5's fingernails were, "Yucky and needed to be cleaned." NA-C stated she was going to ask one of the evening shift girls to clean them tonight. On 12/30/2015 at 2:13 p.m., licensed practical nurse (LPN)-B verified through an observation R5 had brown debris underneath, "the majority of her nails." LPN-B stated the condition of her nails	2 860		

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2 860	Continued From page 20 was not acceptable and verified they needed to be clean. LPN-B stated staff needed to clean R5's nails and wash her hands after meals and inspect her finger nails to ensure they were clean. LPN-B verified R5's care plan did not specifically address nail care, but stated she would consider nail care to be a part of resident grooming. LPN-B verified R5's care plan was not followed for R5 to appear well groomed. On 12/30/2015 at 3:29 p.m., the administrator stated she expected resident's finger nails to be maintained and cleaned. The administrator stated staff should be washing residents hand and ensuring clean fingernails daily. A policy was requested on ensuring personal hygiene for residents and was not provided. SUGGESTED METHOD OF CORRECTION: The DON could insure that staff are re-inserviced as to their responsibility to provide dependent residents with assistance with nail care according to facility policy. The DON could conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 860		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:	2 910		2/9/16

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2 910	Continued From page 21 A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to evaluate and implement an individualized toileting plan after an increase in urinary incontinence for 1 of 2 residents (R3) reviewed for urinary incontinence. Findings include: R3 was hospitalized from 9/2/15 to 9/8/15 following a fall with femur fracture resulting in decrease of mobility and an increase in staff assistance for toileting. Following hospitalization, R3's urinary incontinence increased from frequently incontinent to always incontinent. However, the facility failed to assess the increase in urinary incontinence and develop an individualized toileting plan in an attempt to restore bladder function to the previous level or the highest attainable level of bladder function. R3's significant change Minimum Data Set dated 8/18/15 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 14, required extensive assist from one staff member for toileting, did not have a toileting program, and was occasionally incontinent of urine. R3's Significant change MDS dated 9/15/15 indicated no cognitive impairment with a BIMS	2 910	Will comply.	

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2 910	Continued From page 22 score of 15, required extensive assist from two staff members for toileting, did not have a toileting program, and was frequently incontinent of urine. R3's fourteen day MDS dated 9/22/15 indicated no cognitive impairment with a BIMS score of 15, required extensive assist from two staff members for toileting, did not have a toileting program, and was always incontinent of urine. R3's significant change MDS dated 12/8/15 indicated no cognitive impairment with a BIMS score of 15, required extensive assist from one staff member for toileting, did not have a toilet program, and was always incontinent of urine. The associated urinary care assessment area (CAA) indicated R3 had urge incontinence and required assistance for transferring and perineal care. The CAA included, "She is incontinent quite often but will alert staff to need to use the toilet. Incontinence products are managed by staff and pericare is completed after incontinence episodes. Will develop Care Plan." R3's Bladder Assessment dated 12/8/15 indicated resident is usually aware of toileting needs and expresses acceptance of incontinence. Assessment further indicated R3 voided correctly, without incontinence, less than once per day and the incontinence is in small amounts. The assessment identified the type of urinary incontinence as mixed. R3's record did not reflect an analysis or evaluation of the decline in bladder function. R3's electronic care plan provided by the facility on 12/30/15 indicated R3 had urge incontinent and unable to reach bathroom/commode on time related to mobility deficit. The care plan directed staff to encourage intake, and report changes in voiding patterns or appearance in urine. The care plan did not direct staff of R3's toileting routines or needs. The indicated type of incontinence on the care plan (urge) did not	2 910		

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2 910	Continued From page 23	2 910		

reflect the assessed type of incontinence that was indicated on the bladder assessment (mixed). The record did not show evidence the care plan was revised to reflect the bladder function changes from occasionally incontinent to always incontinent.
R3's CNA Assignment Card did not reference an individualized toileting schedule or plan.
R3's voiding documentation was reviewed form 10/1/15 through 12/30/15. The documentation reflected always incontinent of urine.
R3's record did not reflect a comprehensive reassessment for an individualized toileting schedule or plan after return from hospital.
During an interview on 12/30/15, at 9:51 a.m. nursing assistant (NA)-A indicated R3 used to put on her call light prior to her fall to use the restroom. NA-A explained R3 didn't use the call light at all anymore to use the bathroom and calls when she is wet so we can change her. NA-A stated R3 was always incontinent now. NA-A indicated toileting was offered every 2-3 hours to everybody.
During an interview on 12/30/15, at 10:30 a.m. assistant director of nursing licensed practical nurse ADON LPN-B indicated residents are not assessed for a toileting plan or schedules and stated, "We don't have toileting programs here, we just offer every 2 hours." LPN-B stated not being sure why there had been an increase in incontinence post hospitalization. In response to the question, "If the resident is wet at every two hour interval, then what do you do? " ADON LPN-B stated, "Then they would change her."
During an interview on 12/30/15, at 12:47 a.m. R3 stated that since she fell and broke her leg she does not ask to get up to use the bathroom anymore. R3 stated she goes to the bathroom in her pants and then calls staff to change her. R3 explained reason for intentional incontinence was

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2 910	Continued From page 24 out of fear of falling again and was not comfortable. R3 indicated an awareness of urge to void and has not been offered alternatives such as bedside commode or bedpan. During an interview on 12/30/15, at 1:07 p.m. NA-B stated R3 was more incontinent than prior to fall and explained R3 does not want to go to the toilet at all, she refuses. NA-B did not know the reason for refusals. NA-B explained R3 could walk and use a walker but R3 would rather have staff lift and put her on the toilet. NA-B indicated R3 was not on a toileting schedule and was not aware of any interventions to decrease the amount of urinary incontinence. During an interview on 12/30/15, at 1:48 p.m. administrator (also a registered nurse) explained the process for developing an individualized toileting plan/schedule. Administrator stated, "Everybody should not have the same toileting plan or schedule, they should be specific to her needs." Stated, the schedule should be in the care plan. Facility policy Bowel and Bladder Assessment last revised 3/07 does not meet current standards of practice for development, care planning, and implementation of individualized toileting plan to improve, maintain, or prevent increase in urinary incontinence. SUGGESTED METHOD OF CORRECTION: The facility could review the state requirements, review their policies/procedures and revise them to include individualized toileting schedules/plan/program, the facility could then develop assessments and tools and educate staff on how to assess, implement, and maintain an individualized toileting plan for all residents. The facility could then develop and implement an auditing system as part of the quality assure process to maintain compliance.	2 910		

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2 910	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 dietary low temperature/chemical sanitation dishwasher maintained water temperatures of 120 degrees for wash and rinse cycles. This had the potential to affect all 19 residents residing in the facility, staff and visitors who utilized dietary dishes. Findings include: During the initial kitchen tour on 12/28/15, at 8:45 a.m., dietary aide (DA)-A washed a load of dishes in the dishwasher. At that time, DA-A checked the dishwasher wash cycle temperature on the dishwasher dial, which read 102 degrees, and checked the rinse cycle on the dial, which read 105 degrees. DA-A used a chlorine test paper strip to monitor chemicals which read 100 parts per million (ppm). Dishwasher logs for 12/1/15 to 12/28/15, were reviewed, which revealed dishwasher rinse cycle temperatures 100-120 degrees. During interview at that time, dietary manager verified the temperatures recorded on the facility dishwasher temperature log were the	21015	Will comply.	2/9/16

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21015	Continued From page 26	21015		

rinse cycle temperatures. Dietary manager stated she was aware of the low dishwasher temperatures. Dietary manager stated she had reported the low temperatures to administration several times. Dietary manager stated she expected the dishwasher wash temperature to be 130 degrees and the rinse temperature to be 120 degrees. Dietary manager verified the dishwasher was a low temperature dishwasher.

During observations on 12/28/15, at 10:25 a.m., dietary manager ran one dishwasher cycle and then checked water temperatures on the second cycle, with wash 105 degrees and rinse 105 degrees. During interview at that time, dietary manager stated had first noticed low dishwasher temperatures, possibly in 9/2015, when maintenance department lowered water temperatures in resident rooms. During interview at that time, dietary manager verified the chemical solution used in the dishwasher was Ecolab Ultra San, liquid sanitizer for low temperature machines.

During interview on 12/28/15, at 10:35 a.m., dietary manager verified 8/16/15, dishwasher rinse temperature was 135 degrees and verified the temperatures had been 120 and below since 8/16/15.

Facility Dishwasher Temperatures and PPM (parts per million) Levels logs were reviewed for 8/16/15 through 12/28/15. Dishwasher rinse temperatures and PPM chemical test strips were checked one to three times daily with the following identified:
8/16/15-breakfast 135 degrees, PPM-100.
8/17/15-breakfast 112 degrees, PPM-100; lunch-120 degrees, PPM-100.
308 rinse temperatures were recorded with 82

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21015	Continued From page 27 recordings at 120 degrees,and 226 rinse recordings were 100 to 115 degrees. Observations on 12/28/15, at 11:20 a.m., revealed signage on the dishwasher with the following information: Ecolab--minimum wash--120 degrees; minimum rinse--120 degrees. The signage temperatures were verified by DA-A and dietary manager. During interview at that time, dietary manager verified no documented evidence of notifying administration of low dishwasher temperatures. During interview on 12/28/15, at 11:22 a.m., administrator verified she was aware of the low dishwasher temperatures. During interview on 12/28/15, at 11:43 a.m., director of nursing stated facility had no gastroenteritis symptoms since 8/16/15. Document review of manufacturer's instructions for the dishwasher provided by facility, revealed the following directions: operating temperatures-wash (minimum) 120 degrees Fahrenheit and ; sanitizing rinse (min) 120 degrees Fahrenheit. Document review of facility "Dishwashing and Equipment" policy dated 10/18/11, revealed the following: #5." The wash water temperature shall be within 120-140 degrees;" #6. "The sanitizing ratio shall be within 50-100." SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures regarding safe dishwasher operating temperatures based off the manufacturer's recommendations and guidelines. The facility	21015		

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21015	Continued From page 28 could then develop a system for notification and repair of the equipment in a timely manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a multi-use glucometer was correctly disinfected according to the manufacturer's recommendations for disinfecting re-usable equipment this had the potential to effect 1 of 10 residents (R7) who used the same glucometer for checking blood sugars. Findings include: R7 was observed on 12/20/15 at 11:50 a.m. when licensed practical nurse (LPN)-C washed hands, donned gloves, and obtained a blood sugar reading from R7 using a multi-use glucometer. Following the procedure LPN-C returned to the medication cart, rubbed a PDI Super Sani-Cloth Germicidal Disposable Wipe on the glucometer thoroughly for approximately five seconds, and placed the glucometer on the medication cart where it air dried within seconds. During an interview with LPN-C directly following the procedure, LPN-C stated an unawareness of the manufacturer's direction on the container the equipment needed to be continuously wet for two	21375	Will comply.	2/9/16

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21375	Continued From page 29 full minutes for optimal disinfectants effectiveness. Manufacturer's instruction on the container for disinfecting included, allow treated surface to remain wet for two minutes and use additional wipes to assure surfaces have the continuous full two minute contact time. Facility procedure Glucometer Cleaning and Disinfecting (not dated) indicated, "All glucometers must be cleaned after each patient use, in between patients, and after contact with blood or body fluids. Wipe down with Sani-Coths (purple top)-CONTACT TIME for purple wipes is 2 minutes." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff on the need to follow current guidelines for disinfecting a multi use glucometer. TIME PERIOD FOR CORRECTION: Seven (7) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance	21426		2/9/16

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21426	Continued From page 30 regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide annual tuberculosis (TB) education to all employees, failed to ensure all employees received TB symptom screeners and failed to perform TB skin test (TST) or blood test (IGRA) prior to having resident contact for 5 fo 5 employee (EE-1, 2, 3, 4 & 5) reviewed in the sample. In addition the facility failed to provide symptom screeners and TB test to 4 of 4 residents (R16, 7, 27, and 900) newly admitted into the facility. Findings include: Employee TB control and prevention program: Employee (EE)-1's records reflected a hire date of 4/1/14. The record lacked evidence of a TB symptom screen. The record indicated the first step TST was administered after the employee had resident contact on 4/7/15. The record also revealed the second step TST was administered 7 days after the first step on 4/14/15. EE-2's records reflected a hire date of 3/23/15. The record indicated the first step TST was administered after the employee had resident contact on 4/1/15. Employee records for EE-3 with a hire date of 2/23/25, EE-4 with a hire date of 7/7/15, and EE-5 with a hire date of 9/2/15 all lacked evidence TST's were administered and evidence TB	21426	Will comply	

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21426	Continued From page 31 symptoms screeners were performed. Resident TB control and prevention program: R16's immunization record lacked evidence of a TB symptom screen. The record indicated the second step TST was due on 8/20/15; the record did not reflect the second step was administered. R7's immunization record lacked evidence of a TB symptom screener. The record indicated the first step TST was administered on 10/2/15 and the second step TST was administered less than 14 days later on 10/14/15. R27's The immunization record lacked evidence of a TB symptom screen. The record reflected the first step TST was administered on 11/4/15 and read negative; the record did not indicate the millimeters of induration. The record further reflected the second step was administered less than 14 days later on 11/16/15. R900's immunization record lacked evidence of a TB symptom screener. The immunization record indicated the first step TST was administered on 12/10/10, however was not read. The record indicated the test was re-administered on 12/18/15 and read negative on 12/20/15 however, did not indicate the millimeters of induration. The record further reflected the second step was given less than 14 days later on 12/25/15. During an interview on 12/20/15, at 1:52 p.m., director of nursing (DON) stated there indicated there had not been a system in place during the orientation process to ensure TB screens were being completed. DON stated they were still working on the new employee orientation process. Documentation of employee annual TB education was requested from the facility administrator on 12/31/15. A policy was returned to the surveyor with a handwritten note, "no dates that I can find" for education. The note also indicated no symptom screeners for residents were located.	21426		

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21426	Continued From page 32 Facility policy Education and Training of Health Care Workers not dated included, "all health care workers should receive education regarding tuberculosis that is relevant to persons in their particular occupational group. Training should be conducted before initial assignment, and the need for additional training should be re-evaluated periodically (once a year)." A facility policy/procedure for resident TB screening was requested and not received. SUGGESTED METHOD OF CORRECTION: The facility could audit all resident and employee records to ensure all TB screens and testing are current. The facility could develop policies/procedures for TB testing and screening of residents and review policies and procedures for employees based on current CDC recommendations and guidelines. The facility could also review their training program and ensure all staff are up to date in TB training. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21426		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to treat 1 of 1 resident (R24) with dignity	21805	Will comply.	2/9/16

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21805	Continued From page 33	21805		

when an incontinent product was partially visible to anyone in the area had been placed underneath R24 while seated in her wheelchair and failed to provide a dignified dining experience for R24.

Findings Include:

INCONTINENCE PAD VISIBLE WHILE SEATED IN WHEELCHAIR LOCATED IN COMMON AREA:

R24, was observed on 12/29/2015 at 6:29 p.m. located in the common area of the facility near the television sitting in a wheelchair with a visible plastic incontinent chuck pad (a pad used to absorb urine) placed underneath her on the cushion of the wheelchair. There were five other residents sitting in the same common area at this time.

On 12/29/2015 at 6:50 p.m., R24 continued to be observed in the common area of the facility sitting in a wheelchair with the plastic incontinent chuck pad placed underneath her. There were five other residents sitting in the same common area.

On 12/29/2015 at 7:03 p.m. R24 continued to be observed in the common area of the facility sitting in a wheelchair with the plastic incontinent chuck pad placed underneath her. There were five other residents sitting in the same common area.

R24's quarterly Minimum Data Set (MDS) dated 12/8/15, revealed R24 had a brief interview for mental status score of 0, which indicated severely impaired cognition, R24 required extensive assist of two for toileting and identified a diagnoses of Alzheimer's disease.

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21805	Continued From page 34 On 12/29/2015 at 7:16 p.m., licensed practical nurse (LPN)-B stated a plastic incontinent chuck pad should not have been placed underneath R24 in her wheelchair. LPN-B stated R24 wore a brief for incontinence and stated the visible chuck pad was a dignity issue. On 12/29/2015 at 7:17 p.m., LPN-B verified through observation the plastic incontinent chuck pad was placed underneath R24 in her wheelchair and she was sitting in her wheelchair in a common area of the facility which was visited by staff, families, and residents. On 12/29/2015 at 7:18 p.m., the administrator verified through observation the plastic incontinent chuck pad was placed underneath R24 in her wheelchair. The administrator stated this would not be something they would practice here at the facility. The administrator stated this was a dignity issue for the R24 and stated she was astounded and would make sure that did not happen again. On 12/29/2015 at 7:22 p.m., a nursing assistant was observed to take R24 back to her room. A gait belt was placed around R24's waist and she required an assist of two nursing assistants to stand. The plastic incontinent chuck pad was removed from the wheelchair, was replaced with a cloth incontinent chuck pad and R24 was sat back down in the wheelchair. Nursing assistant (NA)-D stated they placed the chuck in her wheelchair as R24 was incontinent and she had soaked through her brief and her pants earlier. On 12/29/2015 at 7:32 p.m., the administrator stated it would not be appropriate to use a cloth incontinent chuck pad in R24's wheelchair and verified the cloth chuck pad would also be a dignity issue for resident. On 12/29/2015 at 7:35	21805		

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21805	Continued From page 35 p.m. the administrator verified through observation R24 was sitting on a cloth incontinent chuck pad in her wheelchair in the hallway. On 12/29/2015 at 7:38 p.m., the administrator stated R24 had soaked through her brief earlier and the cushion in her wheelchair was wet. The administrator stated the nursing assistants told her the incontinent products were placed in R24's wheelchair to protect her clothing from getting wet from the cushion. The administrator stated this was still not a good reason to place the chuck incontinent pads in R24's wheelchair. The administrator stated she educated the nursing assistants on dignity for the resident. On 12/29/2015 at 7:46 p.m., R24 was observed to be sitting in the hallway in the wheelchair with a visible cloth incontinent chuck pad underneath her. EVEN THOUGH R24 RECEIVED ADEQUATE FOOD THERE LACKED A DIGNIFIED DINING EXPERIENCE: R24 had been observed on 12/30/2015 at 9:09 a.m. located in the dining room with licensed practical nurse (LPN)-C sitting by R24 assisting her to eat her breakfast. At 9:26 a.m., the telephone hanging on the dining room wall rang, LPN-C left R24 sitting at the table to answer the phone and then left the dining room. LPN-C returned to the dining room at 9:28 a.m. walked over to R24 and asked if she would like another bite and then proceeded to leave R24 at the dining room table and walk to the medication cart which was located outside of the dining room. At 9:30 a.m. LPN-C came back into the dining room, walked around the room as R24 was independently drinking a beverage at this time. At	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00922	A. BUILDING: _____ B. WING _____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21805	Continued From page 36 9:31 a.m. LPN-C again went to the medication cart positioned right outside of the dining room. At 9:31 a.m.. LPN-C reentered the dining room and sat down by R24 and offered to assist her to eat more food. R24 accepted a bite of sausage and a drink of apple juice. LPN-C attempted to provide resident another bite and R24 turned her head away. LPN-C encouraged R24 to drink more of her fluids. R24 accepted drinks of her milk. LPN-C offered another bite of her sausage and R24 accepted the bite of food. LPN-C offered R24 a drink of her juice and R24 took the cup and started to independently drink her juice. LPN-C got the attention of a surveyor and asked if the surveyor had time to watch her continue to complete the medication pass. LPN-C then left R24 sitting at the table with her plate of food and three beverage glasses sitting in front of her. R24 moved the plate around on the table and placed food in one of the cups. There was no staff member present in the dining room at this time. LPN-C was at the medication cart outside of the dining room, preparing medications for another resident. R24 picked up pieces of her food and placed them back down on her plate with her hands, R24 picked up a piece of her sausage and placed it in her mouth. There is no staff member present in the dining room at this time. At 9:42 a.m. LPN-C reentered the dining room to administer another resident their medication. R24 continued to pick up the food off of her plate and place it back down on her plate. At 9:44 a.m. LPN- C again left the dining room to go to the medication cart and there was no staff in the dining room. R24 started to fold the bottom of her clothing protector on top of the dining room table as it was still fastened around her neck. At 9:45 a.m. LPN-C sat back down by R24 and LPN-C used a fork to remove food from one of the cups and started offering R24 drinks of milk and	21805		

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21805	Continued From page 37	21805		

offered her another bite of her sandwich. R24 accepted the bite of the food. Offered resident drink of milk and R24 accepted another bite of food. R24 picked up a piece of the grilled cheese and took a bite independently. R24 accepted another bite of grilled cheese from the nurse and accepted a drink of milk. At 9:51 a.m. R24 accepted another bite of her grilled cheese sandwich. R24 picked up one of her cups and took a drink independently. R24 accepted another bite of food at 9:52 a.m., 9:53 a.m. and 9:55 a.m. LPN-C asked R24 if she would like a cookie. LPN-C knocked on the kitchen door and asked for a soft cookie for R24. LPN-C unwrapped the cookie from the plastic bag and sat the plastic wrapper on the table. LPN-C proceed to clean a table top in the dining room. At 10:01 a.m. LPN-C walked back over to R24, asked her how the cookie was, removed her plate of food then went to the medication cart. At 10:03 a.m. LPN-C reentered the dining room and asked R24 if she was done. At 10:06 a.m. LPN-C wheeled R24 out of the dining room to the day room.

R24's quarterly Minimum Data Set (MDS) dated 12/8/15, revealed R24 had a brief interview for mental status score of 0, which indicated severely impaired cognition, R24 required limited assist of one for eating and identified a diagnoses of Alzheimer's disease.

R24's care plan dated 9/22/15 indicated R24 required limited assist of one staff for eating at times, but at least supervision, with cues to keep on task.

R24's nurse progress noted dated 12/8/15 indicated, "Eating. Requires one aide for assist for eating to feed resident for all meals eating

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21805	Continued From page 38 ability has decreased. Usually eats 75%, has good appetite, no eating concerns or swallowing problems." On 12/31/2015 at 9:19 a.m. LPN-B stated R24 was to receive assist of one to eat. LPN-A stated R24 was able to hold her own glass independently drink and was able to eat finger food independently. LPN-B stated her care plan indicated for meal time R24 required assist of 1 at times, but at least supervision with cues. LPN-B stated her expectation was staff should sit with R24 until she completed her meal. LPN-B verified R24 did not receive a dignified dining experience when the nurse did not supervise R24 during the meal and R24 was observed to play with her food. On 12/31/2015 at 9:29 a.m., the administrator stated she expected staff to provide attention to residents in the dining process. The administrator verified R24 was not treated with respect and dignity when she was having her breakfast during the observed dining experience. An untitled and undated policy on dignity indicated, "We will treat patients, colleagues and visitors with respect, dignity and compassion." SUGGESTED METHOD OF CORRECTION: The facility could review their education and training in providing dignified care of a vulnerable adult and review/implement policies and procedures for assuring dignified care. The facility could provide ongoing education and training and monitor for compliance. TIME PERIOD FOR CORRECTION: seven (7) days.	21805		