### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	WI	٧C	
Faci	lity I	D٠	00922

NO.(L1) 245464  2. STATE VENDOR OR MEDICAL (L2) 363670400  5. EFFECTIVE DATE CHANGE OF (L9)  6. DATE OF SURVEY 02/  8. ACCREDITATION STATUS:		3. NAME AND AD (L3) OSTRANDE (L4) 305 MINNES (L5) OSTRANDE 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	ER CARE AND SOTA STREET ER, MN	<b>REHAB</b>	02 (L7) 13 PTIP 14 CORF	55961 22 CLIA		2. Recertification tion 4. CHOW on 6. Complaint
0 Unaccredited 1 TJC 2 AOA 3 Other	_	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/3	31
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds  14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF 25 (L37) (L38)  16. STATE SURVEY AGENCY REA	25 (L18) 25 (L17) OWN 5 19 SNF (L39)	B. Not in Compl Requirements  ICF  (L42)	nce With equirements be Based On: ecceptable POC liance with Prograt and/or Applied W  IID  (L43)	m aivers:	2. Tech 3. 24 H 4. 7-Da 5. Life	nnical Personnel Jour RN Ay RN (Rural SN Safety Code A* MEETS	7. Med	pe of Services Limit dical Director ent Room Size ls/Room
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:
Lisa Carey. HFE NE	Ш	0.	2/25/2016	(L19)	Kamala Fiske	e-Downing, Er	nforcement Spe	ecialist 03/02/2016 (L20
PA	ART II - TO BE	COMPLETED E	BY HCFA RE	GIONAL	OFFICE OF	R SINGLE S	TATE AGEN	CY
19. DETERMINATION OF ELIGIBILITY  20. COMPLIANCE WITH CIVIL RIGHTS ACT:  1. Facility is Eligible to Participate								
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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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

**Health Regulation Division** 

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, maintaining and improving the health of all Minnesotans

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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

**Health Regulation Division** 

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION  A. Building			DATE OF REV	/ISIT
	B. Wing		Y2	2/19/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
OSTRANDER CARE AND REI	HAB	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).

ITE Y4		<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5
ID Prefix Reg. #	F0170 483.10(i)(1)	Correction	ID Prefix	F0241 483.15		Correction Completed	ID Prefix Reg. #	F0247 483.15(e)(2)		Correction 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			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			
REVIEWS		REVIEWED BY (INITIALS) GPN/kfd	<b>DATE</b> 2/25/201	6	SIGNATURE OF				<b>DATE</b> 2/19/2	2016
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 12/31/20		Y COMPLETED ON			R ANY UNCORRECTED DEFICIENCI				YE	s 🗆 no

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PROVIDER / SUPPLIER / CLIA / MULTIPLE CONSIDENTIFICATION NUMBER A. Building 01 -	STRUCTION MAIN BUILDING 01			DATE OF REVISIT			
245464 <sub>Y1</sub> B. Wing			Y2	2/9/2016 <sub>Y3</sub>			
NAME OF FACILITY		STREET ADDRESS, O	CITY, STATE, ZIP CODE				
OSTRANDER CARE AND REHAB		305 MINNESOTA STR	EET				
		OSTRANDER, MN 559	961				
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 b corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement the survey report form).							
ITEM DATE	ITEM	DATE	ITEM	DATE			
Y4 Y5	Y4	Y5	Y4				



Protecting, maintaining and improving the health of all Minnesotans

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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

**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

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ITE	M		DATE	ITEM				DATE	ITEM			DATE	
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D Prefix	20302		Correction	ID Prefix	20435			Correction	ID Prefix	20560		Corre	ction
Reg. #	MN State Statute 144.6503		Completed	Reg. #	MN Ru Subp. 2	ile 4658.021 2 A.B.	0	Completed	Reg. #	MN Rule 4658.04 Subp. 2	405	Comp	leted
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Reg. #	MN Rule 4658.04 Subp. 3	105	Completed	Reg. #	MN Ru Subp. 2	ile 4658.052	20	Completed	Reg. #	MN Rule 4658.09 Subp. 5 A.B	525	Comp	leted
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D Prefix	21805		Correction	ID Prefix				Correction	ID Prefix			Correc	ction
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	FOLLOWUP TO SURVEY COMPLETED ON							CTED DEFICIEN ES (CMS-2567)		A SUMMARY OF HE FACILITY?		s 🗆	NO

Page 1 of 1 EVENT ID: W1VC12

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: W1VC Facility ID: 00922

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MEDICARE/MEDICAID PROVID     (L1) 245464		3. NAME AND AI (L3) <b>OSTRANDI</b>	ER CARE AN	D REHAB		4. TYPE OF ACTION 1. Initial	ON: 2 (L8)  2. Recertification
2.STATE VENDOR OR MEDICAID (L2) 363670400	NO.	(L4) 305 MINNE (L5) OSTRANDI		er -	(L6) <b>55961</b>	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other er Complaint
6. DATE OF SURVEY 12/3  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	1/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	ING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	25 (L18) 25 (L17)	Compliance1. A <b>X</b> B. Not in Con	ance With equirements e Based On: acceptable POC	gram	And/Or Approved Waivers Of  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SN  5. Life Safety Code  * Code:  * Code:  * B*	6. Scope of S 7. Medical D	Services Limit birector om Size
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 25		ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
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22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION <b>04/01/1987</b>	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail to	NTARY  Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	der Status Change e
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28. TERMINATION DATE:	29	). INTERMEDIARY	CAKKIEK NO.		30. REMARKS		
	(L28)	00040		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



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:

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

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

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

<u>Potential Consequences</u> - 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, Program Specialist

Licensing and Certification Program Health Regulation Division

Kamala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 01/26/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		X3) DATE SURVEY COMPLETED
		245464	B. WING		12/31/2015
	PROVIDER OR SUPPLIER	IAB	;	STREET ADDRESS, CITY, STATE, ZIP CODE 805 MINNESOTA STREET DSTRANDER, MN 55961	120112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	INITIAL COMMENT	ΓS	F 000		
	as your allegation of Department's acceptoriolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 170 SS=F	on-site revisit of you validate that substate regulations has been your verification.		F 170		1/21/16
	communications, in	e right to privacy in written cluding the right to send and ail that is unopened.			
	by: Based on interview facility failed to ens their personal mail practice had the poin the facility. Findings Include: On 12/29/15 at 3:47 attends resident co stated, "We never the facility of the facility.	NT is not met as evidenced and document review, the ure that residents received on Saturdays. This deficient tential to effect all 19 residents of p.m. a resident (R18) who uncil was interviewed and get Saturday mail. The staff rurday to pick up the mail."		Mail will be picked up and deliver staff on a daily basis when there is n delivery.     Audits will be completed on every Saturday for one month, then month times three months, and then quarte one year. Audits will be shared at Q Meetings on a quarterly basis.	nail , , ly rly for
L ABORATOR'	   DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

01/26/2016

**Electronically Signed** 

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

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		245464	B. WING _		12/	31/2015
	PROVIDER OR SUPPLIER  DER CARE AND REH	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 170	services director (A delivered to the res The ASSD stated the mail on Saturdays to the post office are weekends to pick usesidents. The ASS office hours on Saturday. On 12/30/2015 at 2 (NA)-C stated on the nurse and two nurse they do not have the the post office on Sprevious post office to the facility on Saturday on 12/30/2015 at 3 stated she was awareceive mail unoper administrator stated about how the facility would have to look stated she was awareceive mail unoper administrator stated about how the facility would have to look stated she was awaremployees that too getting the mail, but Saturday.  The undated Mail President have the rireceive mail that is	1:04 a.m. the activity/social SSD) stated mail was idents Monday through Friday. The residents do not get their because the mail is delivered and there was not staff on the property and any mail on Saturday for Draws unaware of the post array.  1:02 p.m. nursing assistant the weekends there was one ing assistants working and the staff to pick up the mail from aturdays. NA-C stated a start worker would deliver the mail turdays but stated that person	F 17	70		
F 241 SS=D	within 24 hours, exc scheduled delivery	cept when there is no regularly and pick up-service."  AND RESPECT OF	F 24	.1		2/9/16

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY PLETED
		245464	B. WING		12/:	31/2015
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 241	manner and in an enhances each restull recognition of home to anyone in the arounderneath R24 whand failed to provide for R24.  Findings Include:  INCONTINENCE FIN WHEELCHAIR IN WHEELCHAIR IN AREA:  R24, was observed located in the commente television sitting plastic incontinent of absorb urine) placed cushion of the where sidents sitting in time.  On 12/29/2015 at 60 observed in the commente in a wheelchair with pad placed undernation.	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.  NT is not met as evidenced tion and interview the facility resident (R24) with dignity in product was partially visible ea had been placed hile seated in her wheelchair is a dignified dining experience.  PAD VISIBLE WHILE SEATED LOCATED IN COMMON  Ton 12/29/2015 at 6:29 p.m. mon area of the facility near in a wheelchair with a visible chuck pad (a pad used to be dunderneath her on the elchair. There were five other the same common area at this in the plastic incontinent chuck eath her. There were five other	F 24	1. Education will be provided to a that an incontinent product is not visible when it is necessary to be a resident. Also the importance of providing dignified dining experier Resident 24.  2. A review of all residents will be completed to assure that there was another resident affected by this particle. A review of dining protocol was concard changes were made to assure the dining experience is completed dignified manner.  3. Education will be provided to a by February 15, 2016 to review the importance of dignity being provided aring for them.  4. Monitors will be completed on basis for a month, then monthly formonths and then quarterly to assic continued appropriate practices. will be submitted to the QAA Meed quarterly basis.	to be used for force for as not practice. It is a feed while a weekly or three ure Reports	
	observed in the cor in a wheelchair with pad placed undernoresidents sitting in t	mmon area of the facility sitting the plastic incontinent chuck				

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245464	B. WING			12/	31/2015
	PROVIDER OR SUPPLIER  IDER CARE AND REH	IAB		STREET ADDRESS, CITY, STATE, 2 305 MINNESOTA STREET OSTRANDER, MN 55961	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 241	in a wheelchair with pad placed underner residents sitting in the R24's quarterly Min 12/8/15, revealed Finental status score impaired cognition, of two for toileting a Alzheimer's disease.  On 12/29/2015 at 7 nurse (LPN)-B state pad should not hav R24 in her wheelch brief for incontinent pad was a dignity is p.m., LPN-B verified plastic incontinent cunderneath R24 in sitting in her wheelch facility which was viresidents.  On 12/29/2015 at 7 verified through obsincontinent chuck pR24 in her wheelch this would not be so here at the facility. was a dignity issue was astounded and happen again.  On 12/29/2015 at 7 was observed to talgait belt was placed.	inmon area of the facility sitting the plastic incontinent chuck eath her. There were five other he same common area.  imum Data Set (MDS) dated 24 had a brief interview for of 0, which indicated severely R24 required extensive assist and identified a diagnoses of extensive assist and identified a diagnoses of extensive assist and identified a diagnoses of extensive assist and identified a diagnose of extensive assist and stated and stated the visible chuck extensive as and stated the visible chuck is and stated was placed therefore wheelchair and she was chair in a common area of the sited by staff, families, and	F 2	41			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245464	B. WING		12	2/31/2015		
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, Z 305 MINNESOTA STREET OSTRANDER, MN 55961		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 241	removed from the value a cloth incontinent oback down in the walk (NA)-D stated they wheelchair as R24 soaked through here.  On 12/29/2015 at 7 stated it would not be incontinent chuck powerified the cloth challed the cloth chal	ncontinent chuck pad was wheelchair, was replaced with chuck pad and R24 was sat heelchair. Nursing assistant placed the chuck in her was incontinent and she had brief and her pants earlier.  32 p.m., the administrator be appropriate to use a cloth ad in R24's wheelchair and uck pad would also be a ident. On 12/29/2015 at 7:35 tor verified through as sitting on a cloth incontinent neelchair in the hallway.  38 p.m., the administrator alked through her brief earlier her wheelchair was wet. The did the nursing assistants told products were placed in R24's cother clothing from getting wet the administrator stated this reason to place the chuck R24's wheelchair. The dishe educated the nursing	F 2	241				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245464	B. WING		12	/31/2015	
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP C 305 MINNESOTA STREET OSTRANDER, MN 55961			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE	
F 241	practical nurse (LPI her to eat her break the telephone hang rang, LPN-C left R2 the phone and then returned to the dinir over to R24 and as bite and then procedining room table a which was located 9:30 a.m. LPN-C cawalked around the independently drink 9:31 a.m. LPN-C accart positioned right 9:31 a.m. LPN-C resat down by R24 armore food. R24 accdrink of apple juice. resident another bit away. LPN-C encounter fluids. R24 accepted the brack accept	dining room with licensed N)-C sitting by R24 assisting stast. At 9:26 a.m., ing on the dining room wall 24 sitting at the table to answer left the dining room. LPN-C arg room at 9:28 a.m. walked ked if she would like another eded to leave R24 at the nd walk to the medication cart outside of the dining room, At ame back into the dining room,	F 2	41			

			E SURVEY PLETED				
		245464	B. WING			12/3	31/2015
	PROVIDER OR SUPPLIER	AB		3	STREET ADDRESS, CITY, STATE, ZIP CODE 805 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	placed it in her moupresent in the dining a.m. LPN-C reenter administer another continued to pick upplace it back down LPN- C again left the medication cart and dining room. R24 significant clothing protector of as it was still fasten a.m. LPN-C sat back used a fork to remove and started offering offered her another accepted the bite of drink of milk and R2 food. R24 picked up and took a bite indeanother bite of grilled accepted a drink of accepted a drink of accepted another bite of sandwich. R24 picked took a drink indeperant another bite of food 9:55 a.m. LPN-C accookie. LPN-C known asked for a soft cookie. LPN-C known asked her how the food then went to a.m. LPN-C reenter R24 if she was don	up a piece of her sausage and ath. There is no staff member of room at this time. At 9:42 red the dining room to resident their medication. R24 of the food off of her plate and on her plate. At 9:44 a.m. are dining room to go to the dining room to go to the dining room to go to the dining room to find the bottom of her not pof the dining room table are daround her neck. At 9:45 ck down by R24 and LPN-C over food from one of the cups. R24 drinks of milk and bite of her sandwich. R24 for the food. Offered resident expendently. R24 accepted another bite of a piece of the grilled cheese expendently. R24 accepted at 9:52 a.m., 9:53 a.m. and sked R24 if she would like a coked on the kitchen door and okie for R24. LPN-C kie from the plastic bag and per on the table. LPN-C table top in the dining room. At walked back over to R24, cookie was, removed her plate of the dining room and asked e. At 10:06 a.m. LPN-C the dining room to the day the dining room to the day	F 2	241			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245464	B. WING _		12	/31/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 305 MINNESOTA STREET OSTRANDER, MN 55961			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 241	12/8/15, revealed freental status scorimpaired cognition one for eating and Alzheimer's diseas.  R24's care plan darequired limited as times, but at least son task.  R24's nurse progresindicated, "Eating, for eating to feed reability has decreas good appetite, no exproblems."  On 12/31/2015 at 9 was to receive ass LPN-A stated R24 independently drint food independently indicated for meal times, but at least stated her expecta R24 until she comp R24 did not receive when the nurse did meal and R24 was food.  On 12/31/2015 at 9	nimum Data Set (MDS) dated R24 had a brief interview for e of 0, which indicated severely, R24 required limited assist of identified a diagnoses of e.  Ited 9/22/15 indicated R24 sist of one staff for eating at supervision, with cues to keep ess noted dated 12/8/15 Requires one aide for assist esident for all meals eating ed. Usually eats 75%, has eating concerns or swallowing eating concerns or swallowing example to hold her own glass and was able to eat finger example. LPN-B stated her care plan time R24 required assist of 1 at supervision with cues. LPN-B tion was staff should sit with bleted her meal. LPN-B verified example a dignified dining experience in not supervise R24 during the observed to play with her	F 24	11			
	residents in the dir verified R24 was n	ed staff to provide attention to ning process. The administrator ot treated with respect and was having her breakfast during					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3)			SURVEY PLETED		
		245464	B. WING _		12/3	31/2015
	PROVIDER OR SUPPLIER  DER CARE AND REH	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	indicated, "We will t	_	F 24	1		
F 247 SS=D	483.15(e)(2) RIGHT ROOM/ROOMMAT A resident has the r	T TO NOTICE BEFORE	F 24	.7		1/30/16
	by: Based on interview facility failed to give incoming roommate who received two notes and the findings Include: R13 was interviewed R13 indicated she had not been notified roommate. On 12/30/2015 at 1 services director (AR13 had a roommate September 2015 who moved in. The ASS document roommate was not sure if anotes ASSC stated she woof notifying a reside roommate. The ASS	and document review, the appropriate notice of es for 1 of 1 resident (R13) ew roommates.  and on 12/29/15 at 2:32 p.m., and roommate changes and ed previously of getting a  1:01 a.m. the activity/social SSD) stated she was aware te move into her room in then her current roommate D stated she did not the change notifications and ther staff member did. The ras not involved in the process ent they were getting a new DD stated she could not either residents were getting		<ol> <li>Resident 13 does have a roomr this time and is aware of that.</li> <li>A policy was developed to make that all residents are notified of a chin room or roommate.</li> <li>Staff will be educated on the new policy and where and when to docu room changes and the notification or resident of such an occurrence.</li> <li>A follow up will be completed by administrative nursing to assure the documentation and notification did or regarding change of room and room The DON/Designee will complete the review after each room/roommate of monthly times three months and the quarterly for one year.</li> </ol>	e sure nange w iment of the at occur nmate. ne change	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245464	B. WING		12/31/2015
	PROVIDER OR SUPPLIER  DER CARE AND REH	АВ	3	TREET ADDRESS, CITY, STATE, ZIP CODE  05 MINNESOTA STREET  DSTRANDER, MN 55961	
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F 247 F 250 SS=D	responsible at this to the control of the control o	commates as she was not time for informing them.  221 p.m., licensed practical and normally if a resident was roommate we let the resident PN-B stated the notification and under the social services.  227 p.m., the administrator could be notified they are mate prior to the resident hinistrator stated staff should cation in the resident's.  3 a.m., the business office 13 had two new roommates in had a new roommate move in 15.  3 ion of a new roommate was provided.  ISION OF MEDICALLY SERVICE  Divide medically-related social maintain the highest I, mental, and psychosocial	F 247		2/9/16
	by: Based on observat	NT is not met as evidenced ion, interview, and document ailed to evaluate and		R3 was seen by her attending physician. It was decided by her atter	nding

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245464	B. WING			12/3	31/2015
	PROVIDER OR SUPPLIER	IAB		30	TREET ADDRESS, CITY, STATE, ZIP CODE 05 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	symptoms of deprea fracture with hosp anti-depressant and for 1 of 1 resident (Findings include: R3 was hospitalized surgical repair of a return back to the fa R3 displayed an include behaviors and a su symptoms of depreaded the facility evaluated develop a plan of cand depressive syntematical record did not reflect notified timely of R3 behaviors. R3 receimedication) dosage 7.5 milligrams (MG every 3rd day on 6 mg ever three days orders. R3's physician sign 11/10/15 included of disorder and demedisturbance. R3's significant chadated 8/18/15 indiction with a Brief Intervies score of 14. The Pa (PHQ-9, mood-mora score of 1 with detired or having little the assessment penot have any behav period. The MDS resident in the sidner of the MDS resident	tions after an increase in ssion was identified following bitalization and a titration of and an acute change in condition	F 2	250	not to increase her anti-depressant 2. Reviewed all residents PHQ-9s (current and prior) for any significar increase or decrease and followed through accordingly. 3. PHQ9s and Geriatric Depression is completed on all admission, quar and with significant changes. They reviewed with the previous PHQ9 to determine if a care plan needs to be implemented or revised. 4. DON/Designee will complete au careplans and PHQ9s on a monthly for three months and then quarterly one year to assure continued comp Reports will be given at QAA Meetin quarterly basis.	n Scale rterly, will be c e dits on y basis for	

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		TE SURVEY MPLETED
		245464	B. WING		12	/31/2015
	PROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	indicated no cognitisame PHQ-9 score frequency. The MD behaviors and used medication. The M depression with the medication.  R3's 14 day MDS d cognitive impairment and verbal behavior increase in mood so The PHQ-9 indicated pleasure in doing the tired or having little time, and having ponearly every day. The diagnosis of depression and the following in an antidepressant medicated and for possible appropriate. Staff mand for adverse sid develop care plan, R3's significant chain dicated no cognitic continued to show rof 8 and no change R3's current signed 11/10/5 included Remouth every three of three days was the gradual dose reductive previous does	nge MDS dated 9/15/15 ve impairment and had the with the same symptoms and S also reflected R3 had no	F 2	50		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245464	B. WING		12	/31/2015	
	PROVIDER OR SUPPLIER	АВ		STREET ADDRESS, CITY, STAT 305 MINNESOTA STREET OSTRANDER, MN 55961	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 250	6/10/15 included, "that on 2/4 we decr [Remeron] 7.5 mg of PHQ-9 score still reit to every 3rd day she is tolerating this physician saw R3 of however no Physicial decline in depression the 14 day MDS da R3's electronic care facility on 12/30/15. Use of an anti-depression of an anti-depression of an anti-depression of the decline of the decline of the decline of the decline in depressive sympton assessment. R3's mood/behavior reviewed from Augu According to the decline of the declin	History of depression. Note eased her Mirtazapine every other day and her emains zero. We will decrease for a couple of months and if s, then we will stop. The n 8/11/15 and on 9/9/15, an visit notes addressing R3's on/behaviors as found during	F 2	250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245464	B. WING		1:	2/31/2015	
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 250	assistant director of practical nurse (LP) done with increase stated, the resident or socialize and that performed doctors the physician of R3 and depression and been notified. In resussessments and a result of increase symptoms?" ADOI and would have to During an interview social worker (SW) conducted the PHC aware of the increase SW-A stated she did data collected for the physician was not reproved an indicated mild deprenotified of a score of During an interview LPN-C stated a not physical behaviors time went on the bear exported not knowing changed. LPN-C stand did not want to During an interview SW-A indicated the trying to get her to grefuses to come out do nails. SW-A state wants us to encour	od or behaviors. on 12/30/15, at 10:30 a.m. f nursing (ADON) and licensed N-B) was asked, "What was in PHQ-9 score?" ADON doesn't come out of her room it's hard. ADON stated she rounds; she had not notified 's deterioration in behavior d the physician should have sponse to the question, "What evaluation were performed as in behaviors and depressive N indicated she was not aware check with the administrator. on 12/30/15, at 2:52 a.mA indicated she had Q-9 assessment and was se in depressive symptoms. Id not do an evaluation of the ne assessment, and the notified of the change in the use the score of 8 only ession, the physician would be of 9 or higher. on 12/31/15, at 10:07 a.m. iceable increase in verbal and after hospitalization and as ehaviors improved. LPN-C ng why the behaviors had ated R3 does not like change	F 2	250			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	` '	E SURVEY IPLETED
		245464	B. WING _		12/	31/2015
	PROVIDER OR SUPPLIER	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE  305 MINNESOTA STREET  OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279 SS=D	was to stay at home watch TV. SW-A stay of her room because best thing for her." activities on her. At tolerance was not lost stated one on one was revices is on the coccurred, however, documentation or cocurred, however, documentation or cocurring an interview nursing assistant (Nafter she broke her behaviors. NA-A stay behaviors subsided NA-A reported allow and in bed to decreget mad at us for the Afacility policy was 483.20(d), 483.20(k) COMPREHENSIVE A facility must use to develop, review a comprehensive plant The facility must deplan for each resided objectives and time medical, nursing, and needs that are iden assessment.  The care plan must to be furnished to a highest practicable	home, life pattern for years with the blinds closed and ated, "I felt that having her out e of social isolation was the SW-A stated we do not force nevaluation of the R3's social ocated in the record. SW-A visits for activities and social are plan, and visits had SW-A stated there was no alendar of visits. on 12/31/15, at 10:44 a.m. IA)-A stated R3 was difficult leg; R3 displayed more ated the physical and verbal when therapy was completed. Ving R3 to stay in her room ased the behaviors; R3 would lling when it was therapy time. requested and not received. E)(1) DEVELOP E CARE PLANS	F 25			2/9/16

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
		245464	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER	IAB	3	TREET ADDRESS, CITY, STATE, ZIP CODE  05 MINNESOTA STREET  OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	§483.25; and any s be required under § due to the resident' §483.10, including under §483.10(b)(4	ervices that would otherwise §483.25 but are not provided is exercise of rights under the right to refuse treatment	F 279			
	Based on interview facility failed to dev that included individ 2 of 2 residents (R3 incontinence and indevelop care plan i (blood thinner med control medication) reviewed for unnec Findings include:  LACK OF INDIVIDI	n addition the facility failed to interventions for Coumadin ication) and digoxin (heart rate for 1 of 5 residents (R23) ressary mediations.		<ol> <li>R3 and R6's care plans were reand revised to indicate individualize scheduled toileting. R 23's care planguaged for the Coumadin and digard administration and monitoring.</li> <li>All care plans will be reviewed a updated as needed for toileting and medication administration.</li> <li>A policy will be developed and implemented on care plan initiation revisions.</li> <li>DON/Designee will complete au</li> </ol>	ed an was exin and d and	
	ASSESSMENT: R3 was hospitalized following a fall with decrease of mobility assistance for toiled R3's urinary inconting frequently to always to develop a compareflect the changes R3's significant changed to develop a compareflect the changes R3's significant changed to the changes R3's significant changed the changes R3's significant	d from 9/2/15 to 9/8/15 femur fracture resulting in y and an increase in staff ting. Following hospitalization, nence increased from s incontinent. The facility failed rehensive urinary care plan to of R3's voiding habits. Ange Minimum Data Set (MDS) ated no cognitive impairment of the facility failed rehensive urinary care plan to of R3's voiding habits. Ange Minimum Data Set (MDS) ated no cognitive impairment of the facility		care plan completion and accuracy incontinent resident and those who specific medication needs (coumad digoxin etc.) on a weekly basis for month and then monthly times thre months and then quarterly. Result audits will be shared at quarterly Q Meetings.	have din & one e s of	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245464	B. WING			12/:	31/2015
	PROVIDER OR SUPPLIER	IAB		3	TREET ADDRESS, CITY, STATE, ZIP CODE  05 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	extensive assist of significant change I no toileting program urine and required for toileting. The as assessment area (incontinence and retransferring and pe "She is incontinent need to use the toil managed by staff a incontinence episor Facility Bladder assindicated resident is needs and express incontinence. Asse voided correctly, wi once per day and thamounts. The asse urinary incontinence R3's electronic care on 12/30/15 indicated and unable to reach related to mobility of staff to encourage if voiding patterns or plan did not direct so or needs. The care assessed type of in R3's CNA Assignmentividualized toileti R3's voiding diary withrough 12/30/15. incontinent of urine During an interview nursing assistant (Non her call light prices)	of urine and required two staff for toileting. The MDS dated 12/8/15 indicated or trail, always incontinent of extensive assist of one staff sociated urinary care CAA) indicated R3 had urge equired assistance for rineal care. The CAA included, quite often but will alert staff to et. Incontinence products are nd pericare is completed after des. Will develop Care Plan." sessment dated 12/8/15 is usually aware of toileting es acceptance of esment further indicated R3 thout incontinence, less than the incontinence is in small essment identified the type of eas mixed. It is plan provided by the facility ed R3 had urge incontinent in bathroom/commode in time deficit. The care plan directed intake, and report changes in appearance in urine. The care staff of R3's toileting routines plan did not reflect the continence (mixed). The care did not reference and ing schedule or plan.  The diary reflected always	F2	279			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245464	B. WING		12	2/31/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 305 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	light at all anymore when she is wet so stated R3 was alwaindicated toileting veverybody that need During an interview assistant director on nurse (LPN)-B indicassessed for a toile stated, "We don't have just offer every being sure why the incontinence post have response to the quevery two hour interview administrator (also the process for devioleting plan/sched "Everybody should plan or schedule, the care plan. Facility policy Bower evised 3/07 does in practice for develoimplementation of improve, maintain, incontinence. R6 was identified be incontinent of bladd care plan intervent individualized toilet.	to use the bathroom and calls of we can change her. NA-A ays incontinent now. NA-A was offered every 2-3 hours to eds it.  You on 12/30/15, at 10:30 a.m. of nursing/licensed practical cated residents are not eting plan or schedule and have toileting programs here, 2 hours." LPN-B stated not ere had been an increase in nospitalization for R3. In estion, "If the resident is wet at erval, then what do you do?" en they would change her." on 12/30/15, at 1:48 p.m. a registered nurse) explained dule. Administrator stated, not have the same toileting hey should be specific to her e schedule should be in their el and Bladder Assessment last not meet current standards of pment, care planning, and individualized toileting plan to or prevent increase in urinary by the facility as always der although the facility lacked ions that included an	F 2	79		
	diagnosis that inclu	uded diabetes mellitus  record of admission.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245464	B. WING		12/	31/2015	
	PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 805 MINNESOTA STREET OSTRANDER, MN 55961			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE	
F 279	The facility identified Minimum Data Set 10/21/15, to require staff for toileting, who toileting program.  Document review of dated 10/29/15, revincontinent of urine program.  Document review of 8/26/14, revealed a incontinence related Approaches include encourage fluid into apply barrier cream revealed a problem of daily living. Applextensive assist of provide perineal can buring interview or nursing assistant (I completed R6's more perineal care after which was soiled which was sometimes were ceived perineal control of the perineal can buring interview or administrator states.	ed R6 on the significant change (MDS), an assessment dated e extensive assistance of two as always incontinent, and had	F 279				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245464	B. WING _			12/31/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 305 MINNESOTA STREET OSTRANDER, MN 55961			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 279	plan.  During interview or administrator verificities for toilet.  Although requeste available.  LACK OF SAFETY TAKING A BLOOD MEDICATION:  R23 received antic care plan intervent to minimize the ris.  R23 had diagnosis heart disease, perichronic atrial fibrilla according to provide the facility identified change Minimum I assessment dated anticoagulant med anticoagulant med milligrams on Mon milligrams the other document review administration recommodin daily from 11/1/15-11/17/15, and to to to to to to administration recommodin daily from 11/1/15-11/17/15, and to	n 12/31/15, at 9:04 a.m., ed R6's care plan lacked staff schedule.  d, no care plan policies were  PRECAUTIONS WHEN THINNER AND CARDIAC  coagulation medication without ions to direct staff in measures k for bruising.  that included chronic ischemic pheral vascular disease, ation, and hypertension der orders dated 12/2/15.  ed R23 on the significant Data Set (MDS), an 10/26/15, to receive ication.  ed physician orders dated physician orders for the ication, Coumadin, 2 day and Friday, and 1.5	F 27	79			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED	
		245464	B. WING			12/	31/2015
	PROVIDER OR SUPPLIER	IAB	•	3	TREET ADDRESS, CITY, STATE, ZIP CODE  05 MINNESOTA STREET  DSTRANDER, MN 55961	, :=·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279	care plan failed to it potential risk for ble direct staff of interview on administrator verific direction for use of minimize the risk of Administrator state instructions for use R23's care plan.  R23 received digox heart rate, without of direct staff in use of R23 had diagnosis heart disease, periper chronic atrial fibrilla according to provid R23's current providorders, dated 12/2/for digoxin 125 mice.	f R23's care plan revealed the dentify use of coumadin, seding/bruising, and did not entions to minimize the risk of 12/31/15, at 9:04 a.m., and R23's care plan lacked staff coumadin and interventions to bleeding/bruising. It is a she expected staff of coumadin to be included in the included in the coumadin to a she expected staff of coumadin to be included in the		279			
	administration reco digoxin daily as ord 10/31/15; daily 11/1 12/1/15-12/30/15.	f facility medication rd revealed R23 received dered from 10/20/15 to /15-11/30/15; and daily					
		f R23's care plan revealed the dentify use of digoxin, and did					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245464	B. WING		·····	12/3	31/2015
NAME OF PROVIDER OR SUPPLIER  OSTRANDER CARE AND REHAB				3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 MINNESOTA STREET 0STRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	not direct staff of inimedication if pulse  Document review of statement regarding checked pulse befor and if pulse less that button at top of comment review on licensed practical in hope nurses were overified the facility less of daily pulse checked digoxin. LPN-A state would not administe system would open medication was not afternoons, were not ranged from 53 to 10.  During interview on administrator verified monitor pulse were plan. Administrator verified monitor pulse were plan. Administrator instructions for use R23's care plan. Administrator defore administrator on the plan interview on the plan interview of the pulse before administration of the plan interview of the pulse before administration of the pulse	facility undated, untitled g R23, which indicated nurse re administration of digoxin an 50, nurse would select blue puter screen and type in not administered.  12/30/15, at 3:20 p.m., urse (LPN)-A stated, "Would shecking the pulse." LPN-A acked documented evidence is before administration of ed if pulse below 50, then er digoxin and computer an area to document why the given.  If facility monitoring R23's vital to 12/30/15, revealed pulses rying hours mornings and of checked daily, and pulses 34.  12/31/15, at 9:04 a.m., and digoxin instructions to not identified in R23's care stated she expected staff of digoxin to be included in dministrator verified the pulse I was not daily pulse checks on of digoxin.	F 2	279			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245464	B. WING		12/	31/2015	
	PROVIDER OR SUPPLIER	IAB	3	STREET ADDRESS, CITY, STATE, ZIP CODE 805 MINNESOTA STREET OSTRANDER, MN 55961	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 282 F 282 SS=D	483.20(k)(3)(ii) SER PERSONS/PER CATTHE SERVICES provided by accordance with eacare.  This REQUIREMENT by: Based on observative and the service of the servi	RVICES BY QUALIFIED ARE PLAN  led or arranged by the facility y qualified persons in ch resident's written plan of  NT is not met as evidenced ion, interview and document ailed to follow the care plan to st of 1 staff and supervision, r 1 of 1 resident (R24) during in, in addition the facility failed an for personal hygiene for 1 bserved to have soiled  NCE FOR MEALS:  led 9/22/15 indicated R24 sist of one staff for eating at supervision, with cues to keep imum Data Set (MDS) dated at the property in the	F 282 F 282		ance for R5's eviewed needs ortance rdex for ans. dits month ly for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245464	B. WING			12/:	31/2015
	PROVIDER OR SUPPLIER	НАВ		30	TREET ADDRESS, CITY, STATE, ZIP CODE 05 MINNESOTA STREET STRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	ability has decreas good appetite, no eproblems."  On 12/30/2015 at 9 to be in the dining nurse (LPN)-C sitti her breakfast. At 9 the telephone hang rang, LPN-C left Rithe phone and ther returned to the diniover to R24 and as bite and proceeded room table and wa positioned right out 9:30 a.m. LPN-C c walked around, R2 beverage at this tinto her medication of the dining room. At the dining room and to assist her to eat bite of sausage and attempted to provid R24 turned her head to drinks of her milk. Her sausage and FLPN-C offered R24 took the cup and sher juice. LPN-C g	ed. Usually eats 75%, has eating concerns or swallowing 2:09 a.m., R24 was observed from with licensed practicaling by R24 assisting her to eat 2:26 a.m., ging on the dining room wall 24 sitting at the table to answer in left the dining room. LPN-C ing room at 9:28 a.m. walked sked if she would like another it to leave R24 at the dining lik to the medication cart, itside of the dining room. At ame back into the dining room, 4 was independently drinking a ine. At 9:31 a.m. LPN-C walked eart positioned right outside of 29:31 a.m. LPN-C reentered in a did a drink of apple juice. LPN-C de resident another bite and and away. LPN-C encouraged of her fluids. R24 accepted LPN-C offered another bite of 124 accepted the bite of food. It a drink of her juice and R24 tarted to independently drink of the attention of a surveyor	F2	282	DEFICIENCY)		
	medication pass. L table with her plate glasses sitting in fr plate around on the of the cups. There	or had time to watch a PN-C left R24 sitting at the of food and three beverage ont of her. R24 moved the table and placed food in one was no staff member present at this time. LPN-C was at the					

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		245464	B. WING		12	/31/2015	
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP COI 305 MINNESOTA STREET OSTRANDER, MN 55961			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 282	preparing medication picked up pieces or back down on her with the food, R24 sausage and place staff member presettime. At 9:42 a.m. It room to administer medication. R24 coof her plate and place of her plate and place at 9:44 a.m. LPN-go to the medication in the dining room. Of her clothing protection the dining room. Of her clothing protection as it was still 9:45 a.m. LPN-C saucepted the bite of drink of milk and R food. R24 picked u and took a bite indeanother bite of grille accepted a drink of accepted another bite of grille accepted another bite of sandwich. R24 picked u and took a drink independent bite of food 9:55 a.m. LPN-C accookie. LPN-C knowsked for a soft cook a drink independent bite of soft cook a drink independent bite of food 9:55 a.m. LPN-C accookie. LPN-C knowsked for a soft cook a drink independent bite of food 9:55 a.m. LPN-C accookie. LPN-C knowsked for a soft cook and the plastic wrap proceed to clean a 10:01 a.m. LPN-C acked her how the	age 24 side of the dining room, ons for another resident. R24 f her food and placed them plate appearing to be playing picked up a piece of her d it in her mouth. There is no ent in the dining room at this LPN-C reentered the dining another resident their ontinued to pick up the food off ace it back down on her plate. C again left the dining room to an cart and there was no staff R24 started to fold the bottom ector on top of the dining room fastened around her neck. At at back down by R24 and to remove food from one of ad offering R24 drinks of milk other bite of her sandwich. R24 f the food. Offered resident 24 accepted another bite of p a piece of the grilled cheese ependently. R24 accepted and the nurse and fimilk. At 9:51 a.m. R24 of the form one of her cups and andently. R24 accepted at 3:52 a.m., 9:53 a.m. and sked R24 if she would like a cked on the kitchen door and okie for R24. LPN-C table top in the dining room. At walked back over to R24, cookie was, removed her plate cookie wrapper threw them in	F 2	82			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CO 305 MINNESOTA STREET OSTRANDER, MN 55961			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	Continued From pa	ge 25	F 28	2			
	medication cart. At the dining room and At 10:06 a.m. LPN-dining room to the dining room at the dining room to the dining room	st of one to eat. was able to hold her own glass and was able to eat finger. LPN-B stated her care plan ime R24 required assist of 1 at supervision with cues. LPN-B ion was staff should sit with eleted her meal. LPN-B verified ing the care plan to provide neal times and supervision with					
	LACK OF PROVID NEEDED:	ING GROOMING WHEN					
	macular degenerati with grooming with groomed. R5's qua (MDS) dated 10/26 extensive assist of	ed 4/16/15 indicated R5 had ion and required supervision a goal for R5 to be well rterly Minimum Data Set /15, identified R5 required one person for personal ied moderately impaired					
	be sitting at dining beverages from he	:24 p.m., R5 was observed to room table drinking her r evening meal. She was rown debris underneath four and right hands.					
	On 12/29/2015 at 6	:27 p.m., R5 stated staff took					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245464	B. WING			12/3	1/2015
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STAT 305 MINNESOTA STREET OSTRANDER, MN 55961	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD E FO THE APPROPRI		(X5) COMPLETION DATE
F 282	care of her fingerna day and stated she seeing.  On 12/30/2015 at 1 residents' nails wer bath days. NA-C st. had dirty nails staff NA-C was asked to the surveyor. NA-C disgusting, they are used her fingers to food underneath he some of R5's nails to get underneath he some of R5's nails to get underneath he some of R5's fingernated R5's fingernated R5's fingernate be cleaned." NA ask one of the ever tonight.  On 12/30/2015 at 2 through an observation underneath "the mastated the condition acceptable and ver LPN-B stated staff wash her hands aft finger nails to ensuverified R5's care pnail care, but stated to be a part of resid R5's care plan was well groomed.	ails once a week on her bath was blind and has a hard time  :55 p.m., NA-C stated e cut and cleaned on their ated if staff noticed a resident cleaned them as needed. o observe R5's fingernails with stated hers are, "Probably every day." NA-C stated R5 eat and stated she will get er fingernails. NA-C stated were so curved it can be hard her nails to clean them. On p.m., during an observation observed to have brown of the stated she was going to hing shift girls to clean them  1:13 p.m., LPN-B verified of the hard her nails was not iffed they needed to be clean. The hard her nails was not iffed they needed to be clean. In eeded to clean R5's nails and er meals and inspect her re they were clean. LPN-B land did not specifically address of she would consider nail care lent grooming. LPN-B verified not followed for R5 to appear was requested and was not	F 2	282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY IPLETED
		245464	B. WING _		12/	31/2015
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312 SS=D	DEPENDENT RES  A resident who is undaily living receives maintain good nutri and oral hygiene.  This REQUIREMENT by: Based on observat review, the facility for 1 of 3 residents (Redaily living).  Finding Include:  R5's quarterly Minimal 10/26/15, identified of one person for	nable to carry out activities of the necessary services to tion, grooming, and personal of the necessary services to tion, grooming, and personal of the necessary services to tion, grooming, and personal of the necessary services and document ailed to ensure clean nails for the necessary of the	F 31	,	ware of the oughout updated all staff ed on ADL e audits on monthly uarterly	
	day and stated she seeing.  On 12/30/2015 at 1 residents' nails were	tils once a week on her bath was blind and has a hard time  :55 p.m., NA-C stated e cut and cleaned on their ated if staff noticed a resident				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245464	B. WING		12/	31/2015
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 312	NA-C was asked to the surveyor. NA-C disgusting they are used her fingers to food underneath her some of R5's nails get underneath her 12/30/2015 at 2:12 with nursing assistate to have brown debrished between the was going to aste clean them tonig.  On 12/30/2015 at 2:12 with nursing assistate to have brown debrished was going to aste clean them tonig.  On 12/30/2015 at 2:12 with ad brown debrished brown debrished brown debrished be clean. LPN-B states was not acceptable be clean. LPN-B states was not acceptable be clean. LPN-B states was not acceptable be clean. LPN-B verified R5's nails and was inspect her finger in LPN-B verified R5's care papear well groome.  On 12/30/2015 at 3 stated she expected maintained and cless aff should be was ensuring clean fing.  A policy was requested.	cleaned them as needed. Tobserve R5's fingernails with stated hers are, "Probably every day." NA-C stated R5 eat and stated she would get er fingernails. NA-C stated were so curved it was hard to nails to clean them. On p.m., during an observation ant (NA)-C, R5 was observed is under her fingernails on stated R5's fingernails were, to be cleaned." NA-C stated sk one of the evening shift girls ht.  113 p.m., licensed practical fied through an observation R5 inderneath, "the majority of her and the condition of her nails and verified they needed to cated staff needed to clean in her hands after meals and ails to ensure they were clean. It care plan did not specifically but stated she would consider it of resident grooming. LPN-B lan was not followed for R5 to each.  129 p.m., the administrator it can be and. The administrator stated hing residents hand and	F 31:	2		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	` '	E SURVEY MPLETED
		245464	B. WING _	····	12/	/31/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 315 F 315 SS=D	483.25(d) NO CAT RESTORE BLADE  Based on the residents who enter indwelling catheter resident's clinical of catheterization was who is incontinent treatment and servinfections and to refunction as possible.  This REQUIREME by: Based on observative review the facility fimplement an indivincrease in urinary residents (R3) review the facility fimplement an indivincrease of mobilical assistance for toile R3 was hospitalized following a fall with decrease of mobilical assistance for toile R3's urinary incontinent thousever, the facilical in urinary incontinent individualized toiled restore bladder fur	HETER, PREVENT UTI, DER  Ident's comprehensive acility must ensure that a as the facility without an is not catheterized unless the condition demonstrates that as necessary; and a resident of bladder receives appropriate rices to prevent urinary tract estore as much normal bladder e.  NT is not met as evidenced ation, interview, and document ailed to evaluate and ridualized toileting plan after an incontinence for 1 of 2 ewed for urinary incontinence.  In d from 9/2/15 to 9/8/15 I femur fracture resulting in ty and an increase in staff ting. Following hospitalization, inence increased from ent to always incontinent. Ity failed to assess the increase ence and develop an ing plan in an attempt to action to the previous level or	F 31	1. A toileting program evaluation completed on Resident 3. 2. A review of all other residents facility will be completed and an assessment of their toileting probe completed. Each resident which requires a toileting program impleme 3. An assessment will be completed and an assessment will be completed and an assessment will be completed. An assessment will be completed to assure that an up-to-toileting program is completed a planned. 4. DON/Designee will do weekly for review of toileting program evaluations, then monthly audits	gram will no nave their nted. eted on significant date nd care  v audits  will be	
	R3's significant cha 8/18/15 indicated r Brief Interview for 14, required extens	ble level of bladder function. ange Minimum Data Set dated no cognitive impairment with a Mental Status (BIMS) score of sive assist from one staff ng, did not have a toileting		completed for three months and quarterly thereafter. Reports wil at QAA Meeting on a quarterly b	l be given	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245464	B. WING _		12	/31/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 315	urine. R3's Significant chindicated no cogniscore of 15, require staff members for program, and was R3's fourteen day no cognitive impairequired extensive for toileting, did nowas always incont R3's significant chindicated no cogniscore of 15, require staff member for the program, and was The associated ur (CAA) indicated R required assistant care. The CAA incoften but will alert Incontinence production pericare is complete episodes. Will dev R3's Bladder Asseresident is usually expresses acceptate Assessment further without incontinence is assessment identificant incontinence as m R3's record did not evaluation of the dR3's electronic caron 12/30/15 indicated and unable to reactions.	occasionally incontinent of lange MDS dated 9/15/15 tive impairment with a BIMS ed extensive assist from two toileting, did not have a toileting frequently incontinent of urine. MDS dated 9/22/15 indicated rment with a BIMS score of 15, assist from two staff members of thave a toileting program, and inent of urine. ange MDS dated 12/8/15 tive impairment with a BIMS ed extensive assist from one colleting, did not have a toilet always incontinent of urine. Inary care assessment area as had urge incontinence and the for transferring and perineal luded, "She is incontinent quite staff to need to use the toilet. The sament dated 12/8/15 indicated aware of toileting needs and ance of incontinence. The incontinence of incontinence. The indicated R3 voided correctly, the insmall amounts. The fied the type of urinary	F 31	5			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245464	B. WING		12	/31/2015	
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP COD 305 MINNESOTA STREET OSTRANDER, MN 55961	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 315	staff to encourage voiding patterns or care plan did not di routines or needs. incontinence on the reflect the assesse indicated on the bla The record did not was revised to reflectanges from occa incontinent.  R3's CNA Assignm individualized toilet R3's voiding docum 10/1/15 through 12 reflected always inc R3's record did not reassessment for a schedule or plan af During an interview nursing assistant (I on her call light prior restroom. NA-A ex light at all anymore when she is wet so stated R3 was alwaindicated toileting veverybody.  During an interview assistant director on urse ADON LPN-I assessed for a toile stated, "We don't hwe just offer every being sure why the incontinence post if the question, "If the hour interval, then in the restriction of the state of the state of the state of the question, "If the hour interval, then in the state of th	intake, and report changes in appearance in urine. The rect staff of R3's toileting. The indicated type of e care plan (urge) did not d type of incontinence that was adder assessment (mixed). show evidence the care plan ect the bladder function isionally incontinent to always ent Card did not reference and ing schedule or plan. The documentation was reviewed form /30/15. The documentation	F3	215			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245464	B. WING _	<del></del>	12/:	31/2015
	PROVIDER OR SUPPLIER  DER CARE AND REH	AB		STREET ADDRESS, CITY, STATE, ZIP CODE  305 MINNESOTA STREET  OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	stated that since she does not ask to get anymore. R3 states her pants and then explained reason for out of fear of falling comfortable. R3 into void and has not such as bedside con During an interview NA-B stated R3 was to fall and explained the toilet at all, she the reason for refusivally walk and use a walk staff lift and put her R3 was not on a toin aware of any interview administrator (also the process for device toileting plan/sched "Everybody should plan or schedule, the needs." Stated, the care plan. Facility policy Bower revised 3/07 does in practice for develop implementation of in improve, maintain, incontinence. 483.35(i) FOOD PF	on 12/30/15, at 12:47 a.m. R3 e fell and broke her leg she up to use the bathroom d she goes to the bathroom in calls staff to change her. R3 or intentional incontinence was again and was not dicated an awareness of urge been offered alternatives mmode or bedpan. on 12/30/15, at 1:07 p.m. s more incontinent than prior d R3 does not want to go to refuses. NA-B did not know sals. NA-B explained R3 could ker but R3 would rather have on the toilet. NA-B indicated leting schedule and was not entions to decrease the nontinence. on 12/30/15, at 1:48 p.m. a registered nurse) explained eloping an individualized ule. Administrator stated, not have the same toileting sey should be specific to her e schedule should be in the land Bladder Assessment last not meet current standards of oment, care planning, and ndividualized toileting plan to or prevent increase in urinary	F 31			1/11/16
SS=F	STORE/PREPARE/ The facility must -	SERVE - SANITARY				

	N OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			OATE SURVEY OMPLETED		
		245464	B. WING _		1	2/31/2015
	PROVIDER OR SUPPLIER	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	considered satisfact authorities; and (2) Store, prepare, cunder sanitary conductors.  This REQUIREMENT by: Based on observat	m sources approved or tory by Federal, State or local distribute and serve food litions  IT is not met as evidenced ion, interview, and document	F 3	A booster was purchased f	or the	
	low temperature/ch maintained water to for wash and rinse to affect all 19 resid staff and visitors where the findings include:  During the initial kita a.m., dietary aide (Lin the dishwasher wash codishwasher wash codishwasher dial, who checked the rinse of 105 degrees. DA-A strip to monitor che per million (ppm). In 12/28/15, were revidishwasher rinse cydegrees. During into manager verified the facility dishwash rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect all 19 resident and rinse cycle temperal stated she was aware to affect all 19 resident and rinse cycle temperal stated she was aware to affect all 19 resident and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to affect and rinse cycle temperal stated she was aware to a stated she was aware to a stated she was a stated she was aware to a stated she was aware to a stated she was	eailed to ensure 1 of 1 dietary emical sanitation dishwasher emperatures of 120 degrees cycles. This had the potential ents residing in the facility, no utilized dietary dishes.  The chen tour on 12/28/15, at 8:45 DA)-A washed a load of dishes at that time, DA-A checked the ycle temperature on the iich read 102 degrees, and ycle on the dial, which read used a chlorine test paper micals which read 100 parts Dishwasher logs for 12/1/15 to ewed, which revealed ycle temperatures 100-120 terview at that time, dietary e temperature log were the tures. Dietary manager are of the low dishwasher ary manager stated she had		dishwasher to maintain water temperatures of 120 degrees frand rinse cycles.  2. It was installed on 1/11/16.  3. Temperatures will be monite each meal time wash and docuted. Dietary manager will review documented temperatures on scheduled days of work.	ored durin imented.	g

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245464	B. WING		····	12/:	31/2015
	PROVIDER OR SUPPLIER	IAB		3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 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 PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		BE	(X5) COMPLETION DATE
F 371	several times. Dieta expected the dishw 130 degrees and the degrees. Dietary methodishwasher was a limit of the dishwasher was a limit of the dietary manager rathen checked water cycle, with wash 10 degrees. During in manager stated has temperatures, possimal manager stated has temperatures in resident that time, dietary chemical solution under the dietary chemical solution under the dietary manager veringe temperature machin of the dietary manager veringe temperatures in 18/16/15.  Facility Dishwasher (parts per million) Limit of the dietary manager veringe temperatures in 18/16/15 through 12/16/15 through 12/16/15-breakfast 18/17/15-breakfast 11/17/15-breakfast 11/17/17/17/17/17/17/17/17/17/17/17/17/1	imperatures to administration ary manager stated she rasher wash temperature to be a rinse temperature to be the rinse temperature to be the rinse temperature dishwasher.  Is on 12/28/15, at 10:25 a.m., an one dishwasher cycle and remperatures on the second of degrees and rinse 105 terview at that time, dietary dirst noticed low dishwasher stibly in 9/2015, when the the lowered water sident rooms. During interview manager verified the sed in the dishwasher was liquid sanitizer for low mes.  In 12/28/15, at 10:35 a.m., wrified 8/16/15, dishwasher was 135 degrees and verified ad been 120 and below since of the rooms of the review of the second of the sec	F3	371			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY PLETED
		245464	B. WING		12/:	31/2015
	PROVIDER OR SUPPLIER  IDER CARE AND REH	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961		71/20:0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 35	F 37	1		
	revealed signage of following information Ecolabminimum with rinse120 degrees were verified by DA During interview at verified no docume administration of low During interview on administrator verified dishwasher temper During interview on director of nursing signature of the dishwasher the following direction temperatures-wash	vash120 degrees; minimum . The signage temperatures A-A and dietary manager. that time, dietary manager nted evidence of notifying w dishwasher temperatures.  12/28/15, at 11:22 a.m., ed she was aware of the low atures.  12/28/15, at 11:43 a.m., stated facility had no ptoms since 8/16/15.  If manufacturer's instructions provided by facility, revealed ons: operating (minimum) 120 degrees anitizing rinse (min) 120				
F 425 SS=D	Equipment" policy of following: #5." The wash wate 120-140 degrees;" #6. "The sanitizing	of facility "Dishwashing and dated 10/18/11, revealed the er temperature shall be within ratio shall be within 50-100." RMACEUTICAL SVC - SEDURES, RPH	F 42!	5		2/9/16
	drugs and biologica	ovide routine and emergency als to its residents, or obtain eement described in				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245464	B. WING	·····	12/	31/2015	
	PROVIDER OR SUPPLIER	НАВ	STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 425	unlicensed personilaw permits, but on supervision of a lice.  A facility must prove (including proceduracquiring, receiving administering of all the needs of each.  The facility must enal licensed pharmace.	part. The facility may permit nel to administer drugs if State ly under the general ensed nurse.  ide pharmaceutical services res that assure the accurate g, dispensing, and drugs and biologicals) to meet resident.  imploy or obtain the services of cist who provides consultation e provision of pharmacy	F 4:	25			
	by: Based on observareview the facility faqualified to adminisperipherally inserteresulting in incorreadministration for 1 a PICC line, in add an open multi-dose was appropriately thad expired. This hadmissions requestindings include LACK OF TRAININANTIBIOTICS THER 17 was observed license practical nution.	NT is not met as evidenced tion, interview, and document ailed to ensure LPN-C was ster medications through a d central catheter (PICC), at technique of medication of 1 residents (R17) who had ition the facility failed to ensure a vial of influenza vaccinations discarded after the medication and the potential to effect new ting the influenza vaccination.  IG TO ADMINISTER ROUGH A PICC LINE: to receive IV antibiotic from airse (LPN)-C on 12/31/15 at C line. R17's PICC line was tupper arm. LPN-C washed		1. Staff were educated on protocol. Out dated medica pulled and destroyed. 2. There were no other restime on IVs. Upon admission resident, the policy will be required to administration will monitor for medications and remove at 3. Annual and upon admission (PICC Line) resident, education completed by licensed staff review of medication expirate be done by pharmacy consultant and upon admission. 4. Education criteria will be needed for all procedures particular and upon education.	ation was sidents at this on of an IV eviewed by all istration of IV. sursing for outdated and destroy. sion of IV ation will be . Monthly ution dates will ultant and		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	` '	E SURVEY MPLETED
		245464	B. WING		12	/31/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		31/2013
				305 MINNESOTA STREET		
OSTRAN	IDER CARE AND REF	IAB		OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH- CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 425	R17 the medication administered. LPN blunt tip cannula from removed the sterile then rubbed an alcounter LPN-C did not perfinipection cap as recommend as line flush removed the sterile alcohol swab on the connected the saline and turned it to lock down on the syring forcefully and very saline in all one purcheck the PICC line removed the saline antibiotic ball (type infuse medication we connected the antiblocking cannula that LPN-C then took of hands.  During an interview the observation, LF what parts of the princorrectly during the indicated the proces was taught to her in During an interview LPN-B/assistant did were allowed to ad and education was was asked to provincompleted education.	gloves. LPN-C explained to a was going to be l-C then removed the locking om the sterile package, a cap from the cannula, and shol swab on the sterile end. Form sterilization of the PICC quired to prevent infections. The locking cannula was open. The locking from the wrapper, the cap, and then rubbed an element to be flush to the blunt tip cannula was tit into place. LPN-C pushed the plunger with thumb quite quickly infused the 10 cc's of shing motion. LPN-C did not the for placement. LPN-C did not the flush syringe, uncapped the uses positive pressure to without a pump), and shootic into the same blunt tip at was used for the saline flush. The gloves and washed the washed the infusion procedure. LPN-C dure was performed the way it	F4	education of staff. Monthly aud medication expiration dates will for a year.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION IING	, ,	TE SURVEY MPLETED
		245464	B. WING		12	/31/2015
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 425	(DON) and herself course and there we file for the LPN's in During an interview 11:30 a.m. administ indicated LPN's are education for intravexplaining the tech Administrator indicaperformed correctly During an interview infusion specialist of the hospital where stated the injection alcohol swab or oth least 15 seconds. If blunt tip cannula shalcohol, as they are tip cannula cannot changed after ever purposes. RN-A stachecked every time PICC line to ensure supposed to be another than the consintent of the property of the property infusions. RN-A stated failure to do serious health consintent of blood, then the lice's of normal salininfused. RN-A expline you should new should be administ stop, push, stop mempty. RN-A state	urveyor; the director of nursing had completed the training vere no PICC training dates on the facility.  on 12/31/15, at approximately trator (also a registered nurse) e required to complete venous infusion. After nique LPN-C used, the ated the procedure was not	F 4	125		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245464	B. WING		12	/31/2015
	PROVIDER OR SUPPLIER	IAB		STREET ADDRESS, CITY, STAT 305 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 425	follow the above gumanaged by trained. The facility provided Intravenous Therap. Licensed Practical policy included, "The who has certification Nursing verifying the course in intravenous patients."  The facility provided Catheter Insertion a survey exit date. The "Consult State Nursecope of practice a guidelines. The potechnique that director pulsing motion for the catheter for bloprior to administration solutions. The comincluded the warning RESISTANCE OR ARISE AT ANY TIME THE FLUSH AND ON SPECIALIST OR PINFLUENZA VACOUREMOVED AFTER The medication sto 12/29/15 at 1:20 p. 10 open multi-dose via the vaccination was discarded. During an interview director of nursing was series of the series of	didelines and the PICCs are distaff nurses. did the policy Limited by Procedures for Qualified Nurses (with IV Course). The ne Licensed Practical Nurse, on from the Minnesota Board of the successful completion of a tust therapy, may perform therapy procedures on adult and Care on 1/7/15 after the ne policy directed staff to, see Practice Act for RN/LPN and functions.", as general licy included the flushing the staff to use a push-pause for flushing technique. Aspirate and return to confirm patency ion of medications and plications listed in the policy in all capitol letters "IF LACK OF BLOOD RETURN TEDURING FLUSHING STOP CONSULT IV NURSE	F 4	.25		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	` /	E SURVEY PLETED
		245464	B. WING _		12/	31/2015
	PROVIDER OR SUPPLIER  IDER CARE AND REH	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441 SS=D	outdated medication expectation is the non the vial prior to a During an interview pharmacist-A stated influenza vaccinatio 30 days. The rest nor Facility policy and pordering and Receil last revision date of immediate removal that are outdated, so monitored monthly multi-dose vials required shorter than manufating medication procedure directed sticker on the multi-date not to exceed a manufacturer. The check expiration da "all expired medication active supply and diregardless of amout 483.65 INFECTION SPREAD, LINENS  The facility must es Infection Control Presafe, sanitary and control to the prevent the soft disease and infection Control The facility must es Program under whice	et system to check for in the refrigerator, the urses are checking for dates administration."  1/4/15, at 12:10 p.m. d., "once a multi-dose vial of in is opened, it is only good for eeds to be discarded." rocedure used for Medication ving from Pharmacy with a 8/2014 instructed the and disposal of medications to rage conditions are or per facility policy, uires an expiration date acturer's recommendations to burity and potency. The staff to put a "date opened" dose vial with an expiration 30 days unless directed by policy then directed staff to the prior to administration and action will be removed from the estroyed in the facility, in tremaining."  I CONTROL, PREVENT  I CONTROL, PREVENT  I Program designed to provide a comfortable environment and development and transmission ction.  I Program tablish an Infection Control	F 4:			2/9/16

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	i	COMPLETED	
		245464	B. WING		12/31/2015	
	PROVIDER OR SUPPLIER	IAB	STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 441	should be applied to (3) Maintains a reconductions related to in (b) Preventing Spre (1) When the Infect determines that a represent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each dihand washing is incorpofessional practic (c) Linens Personnel must ha	rocedures, such as isolation, or an individual resident; and ord of incidents and corrective affections.  Pad of Infection and control Program are assigned in the facility must	F 441			
	by: Based on observation review, the facility of glucometer was continuously the manufacturer's disinfecting re-usable potential to effect 1 the same glucomet Findings include: R7 was observed of	NT is not met as evidenced tion, interview, and document ailed to ensure a multi-use rectly disinfected according to recommendations for ole equipment this had the of 10 residents (R7) who used er for checking blood sugars.  In 12/20/15 at 11:50 a.m. when urse (LPN)-C washed hands,		<ol> <li>Education will be provided to all licensed staff regarding the sanitatio glucometers.</li> <li>Meters will be given to each diabethat has blood glucose checks.</li> <li>Upon admission, any resident who diabetic will have a glucometer assign to them for their stay.</li> <li>Audits will be completed on a specheck basis at least weekly, as well</li> </ol>	etic no is a gned	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG			E SURVEY PLETED
		245464	B. WING _			12/	31/2015
	PROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP C 305 MINNESOTA STREET OSTRANDER, MN 55961	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 492 SS=D	reading from R7 us Following the proce medication cart, ruk Germicidal Disposa thoroughly for approplaced the glucome where it air dried wi interview with LPN-procedure, LPN-C smanufacturer's dire equipment needed full minutes for optie effectiveness. Manufacturer's inst disinfecting includeremain wet for two wipes to assure sur two minute contact Facility procedure (Disinfecting (not da glucometers must buse, in between part blood or body fluids (purple top)-CONTAminutes."  483.75(b) COMPLY FEDERAL/STATE/LITHE facility must op compliance with all local laws, regulation accepted profession that apply to professuch a facility.	I obtained a blood sugar ing a multi-use glucometer. dure LPN-C returned to the obed a PDI Super Sani-Cloth oble Wipe on the glucometer eximately five seconds, and oter on the medication cart thin seconds. During an C directly following the stated an unawareness of the ction on the container the to be continuously wet for two mal disinfectants.  Truction on the container for d, allow treated surface to minutes and use additional faces have the continuous full time.  Glucometer Cleaning and ted) indicated, "All be cleaned after each patient cients, and after contact with the Wipe down with Sani-Coths act TIME for purple wipes is 2	F 44	monthly basis to assure con this process for three month quarterly for a year. Report to a the QAA Committee on basis.	ns and th s will be	nen given	2/9/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245464	B. WING _		12/	31/2015
	PROVIDER OR SUPPLIER  DER CARE AND REH	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET OSTRANDER, MN 55961	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 492	by: Based on interview facility failed to implifor 1 of 1 resident (the facility's determ Medicare part A ser Findings include: R20 was given a St Beneficiary Notice (that Medicare A covending on 12/4/201 this determination to further review. It was There was no indicasubmitted this appear When interviewed to business office manhad absolutely no daughter regarding the Director of Nursign the form. The I told by the DON that demand bill. The Bo aware that R20 had When interviewed administrator stated be potentially disconfirst, nursing staff with the resident to determination be suffered to first, nursing staff with the resident had recidetermination be suffered to the state of the stat	v and document review, the lement the appeals process R20) who requested review of ination to discontinue vices.  killed Nursing Facility Advance SNFABN) notice on 12/2/2015 rered skilled services were 5. R20 requested an appeal of the besubmitted to Medicare for its signed by the resident.	F 49	1. Our process and procedure demand billing was reviewed for R 20. R20 did not want to have bill done nor did R20 want furth services. This area was checked 2. A review of our other denials completed. Education will be pall individuals working with the In Denial process.  3. The policy and procedure wireviewed and undated to current requirements.  4. Audits will be done by nursing billing of denials of Medicare Armonthly basis for three months quarterly for one year. Reports provided at QAA Meeting on a cobasis.	r resident a demand er ed in error. was rovided to Medicare A II be it g and on a and then will be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3	) DATE SURVEY COMPLETED
		245464	B. WING			12/31/2015
	PROVIDER OR SUPPLIER	HAB		STREET ADDRESS, CITY, STATE, ZIP CO 305 MINNESOTA STREET OSTRANDER, MN 55961	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 492	When a policy was policy and procedu document titled, Manual: chapter 30 It contained no lang facility when a residual.	requested for demand bill re, the facility provided a edicare Claims Processing of financial liability protections. Guage which directed the dent requested an appeal eare for further review.	F 4	92		

PRINTED: 02/01/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245464

B. WING

12/30/2015

AME OF BROWNER OR SURBLIEF

STREET ADDRESS CITY STATE ZIP CODE

NAME OF	PROVIDER OR SUPPLIER	1	RTREET ADDRESS, CITY, STATE, ZIP CODE	
OSTRA	NDER CARE AND REHAB		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
K 000	INITIAL COMMENTS	K 000		
	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:		EPOC	
	Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			
LABORATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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.

Facility ID: 00922

PRINTED: 02/01/2016 FORM APPROVED OMB NO. 0938-0391

	and the same of th	& MEDICAID SERVICES	(2/0) 1411	TIDI	E CONCERNICATION	(X3) DAT	E SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		PLETED
		245464	B. WING			12/	30/2015
	PROVIDER OR SUPPLIER  DER CARE AND REF	HAB		3	TREET ADDRESS, CITY, STATE, ZIP CODE 05 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	Continued From pa St Paul, MN 55101		К	000		39	
	Angela.Kappenma	nitney@state.mn.us> and					
	DEFICIENCY MUS FOLLOWING INFO	PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done					- ×
	to correct the defic						
	3. The name and/o	or title of the person rection and monitoring to ence of the deficiency.					
	with a partial base	nd Rehab is a 2-story building, ment. This facility was 8 and was determined to be of ruction.					
	The facility has a f corridor smoke de	sprinklered since 1/4/2013. ire alarm system with full tection and spaces open to the nitored for automatic fire ation.					
	The facility has a consus of 20 beds	capacity of 25 beds and had a sat the time of the survey.					

PRINTED: 02/01/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>		E SURVEY MPLETED
		245464	B. WING _		12	/30/2015
	PROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP C 305 MINNESOTA STREET OSTRANDER, MN 55961		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 2	K 00	00		
K 038 SS=D	NOT MET as evide NFPA 101 LIFE SA Exit access is arra	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD nged so that exits are readily nes in accordance with section	K 0	38		2/9/16
	Based on observation facility failed to pro- accordance with the 2000 NFPA 101, S	is not met as evidenced by: ation and staff interview, the ovide means of egress in the following requirements of ection 19.2.1 and 7.2.1.5.4, e 2007 MN State Fire Code,		A new door was purchased on 1/26/16. It will be install 2/9/16.		
	on 12/30/2015, ob Secondary Exit fro repaired and/or re	ween 10:00 AM and 12:00 PM oservation revealed that the m the lower level needs to be placed. Presently, an excessive required to push on the door				
K 062	Facility Maintenan of discovery.	tice was confirmed by the ce Director (Ethan) at the time	ΚO	62		1/30/16

Event ID: W1VC21

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 02/01/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 12/30/2015 245464 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 305 MINNESOTA STREET **OSTRANDER CARE AND REHAB** OSTRANDER, MN 55961 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 062 K 062 Continued From page 3 SS=D Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested 19.7.6, 4.6.12, NFPA 13, NFPA 25, periodically. 9.7.5 This STANDARD is not met as evidenced by: Fire sprinkler flow test inspections will be Based on documentation review and interview completed as required by NFPA 13 (99) with staff, the facility has failed to properly inspect and NFPA 25(98). They will be and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section documented in a log book. 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. 1/30/16 K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 SS=D Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

(X2) MULTIPLE CONSTRUCTION

PRINTED: 02/01/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245464	B. WING		12/30/2015	
,	PROVIDER OR SUPPLIER	HAB	30	TREET ADDRESS, CITY, STATE, ZIP COI D5 MINNESOTA STREET DSTRANDER, MN 55961	DE	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC REGULATORY OR L	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
K 144	Continued From pa	age 4	K 144			
			•			
	Based on docume interview, the facili emergency general requirements of 20	is not met as evidenced by: entation review and staff ty failed to inspect the ator in accordance with the 200 NFPA 101 - 9.1.3 and 1999 6-4.1. The deficient practice residents.		The emergency generator in be completed weekly as dire NFPA regulations.	espection will cted by the	
	on 12/30/2015, do weekly inspection generator revealed	ween 10:00 AM and 12:00 PM cumentation review of the logs for the emergency d that the weekly operational issed for the period of July 06, 015.				
	This deficient prac Facility Maintenand of discovery.	ctice was confirmed by the ce Director (Ethan) at the time				
					Ĭ.	
					a	

Facility ID: 00922



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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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.

Ostrander Care And Rehab January 20, 2016 Page 2

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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 01/26/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00922 12/31/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 305 MINNESOTA STREET **OSTRANDER CARE AND REHAB** OSTRANDER, MN 55961 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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

**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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

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.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 01/26/16

TITLE (X6) DATE

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
OSTRANDER CARE AND REHAB  OSTRANDER, MN 55961  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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			00922	B. WING		12/3	31/2015
PRÉFIX TAG    (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PRÉFIX TAG     2 000   Continued From page 1   2 000     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			JAR 305 MINN	ESOTA STRI	EET		
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	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETE DATE
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.	2 000	Department of Hea you electronically, is necessary for State necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to element of the Minnesota Department's sand the following context in your and identify the date.  Minnesota Department's sand the following contection that you and identify the date.  Minnesota Department of the State Licensing federal software. The assigned to Minnes nursing Homes.  The assigned tag in column entitled "ID statute/rule out of content of the statement of the Suggested of	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  29, 30, & 31, 2015 surveyors of taff, visited the above provider orrection orders are issued. Four electronic plan of have reviewed these orders, when they will be completed.  The ent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for the order appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection.  ARD THE HEADING OF THE WHICH STATES, IN OF CORRECTION." THIS				

Minnesota Department of Health

STATE FORM W1VC11 If continuation sheet 2 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			X3) DATE SURVEY COMPLETED	
7.1.12 . 2.11.	o. co20		A. BUILDING:		00	
		00922	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OSTRANDER CARE AND REHAB			ESOTA STR DER, MN 559			
(VA) ID					ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMONI OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train		2 302			2/9/16
	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.					
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;				
	This MN Requirements	ent is not met as evidenced				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
	00922		B. WING	<del></del>	12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
OSTRANDER CARE AND REHAB			ESOTA STR			
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa	ge 3	2 302			
	Based on interview facility failed to ensicompleted Alzheime failed to provide a completed failed to provide a complete failed to provide a complete failed to provide a complete failed to provide administrator stong an interview the administrator stong that a notification was unable to product a notification for employed indicated there were SUGGESTED MET Director of Nursing review, and/or revise ensure all staff recedure for the procedure of the procedure of the procedure of the procedures. The Director of the procedures of the procedure of th	and document review, the ure all newly employed staff er's/dementia training and description of the facilities to consumers in either written  on 12/31/15, at 12:02 p.m. ated, "to my knowledge we ation letter." The administrator uce completed dementia ees hired in the last year and e no training dates on file.  THOD OF CORRECTION: The or designee could develop, see policies and procedures to eive Alzheimer's training. The or designee could draft a r notification to be given at or residents and family  sing or designee could iate staff on the policies and rector of Nursing or designee toring systems to ensure		Will comply.		
2 435	MN Rule 4658.0210 Assignments	) Subp. 2 A.B. Room	2 435			2/9/16
	must develop and in procedures for add including complaint	complaints. A nursing home mplement written policies and dressing resident complaints, s regarding room assignments t a minimum, the policies and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY			
		00922	B. WING	<del></del>	12/3	31/2015		
	OSTRANDER CARE AND REHAB 305 MINN OSTRAND			ADDRESS, CITY, STATE, ZIP CODE NNESOTA STREET ANDER, MN 55961				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE		
2 435	procedures must in A. a mechanismoresolution of room complaints; and		2 435					
	by: Based on interview facility failed to give incoming roommate who received two n	sed on interview and document review, the cility failed to give appropriate notice of coming roommates for 1 of 1 resident (R13) o received two new roommates.		Will comply.				
	R13 indicated she had not been notified roommate.  On 12/30/2015 at 1 services director (AR13 had a roommate September 2015 with moved in. The ASS	ed on 12/29/15 at 2:32 p.m., nad roommate changes and ed previously of getting a  1:01 a.m. the activity/social SSD) stated she was aware the move into her room in then her current roommate. D stated she did not the change notifications and						
	was not sure if and ASSC stated she wo for notifying a reside roommate. The AS confirm or deny whinformed of new roomesponsible at this to the Confirm or deny whinformed of new roomesponsible at this to the Confirm or deny whinformed of new roomesponsible at this to the Confirm of the Confi	te change notifications and ther staff member did. The ras not involved in the process ent they were getting a new DD stated she could not ether residents were getting ammates as she was not time for informing them.  1:21 p.m., licensed practical ed normally if a resident was roommate we let the resident						

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00922		B. WING		12/3	31/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
OSTRANDER CARE AND REHAR			ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 435	Continued From pa	ge 5	2 435			
	and family know. LPN-B stated the notification would be documented under the social services progress notes.					
	stated residents sho getting a new room moving in. The adm	:27 p.m., the administrator ould be notified they are mate prior to the resident ninistrator stated staff should cation in the resident's				
	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.					
	director of nursing ( with the social work and procedures for of room/roommate educate staff. The I perform audits of re	HOD OF CORRECTION: The DON) or designee could work ter/designee to update policies when to notify the resident(s) changes, and then could DON or designee could also esident records to determine if been notified as appropriate.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 560	MN Rule 4658.0405 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			2/9/16
	comprehensive plat objectives and time long- and short-term	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, vchosocial needs that are				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00922	B. WING		12/3	1/2015
OSTBANDER CARE AND REHAB 305 MINN			DRESS, CITY, S ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
ide ass mu rec substitution of 1 substitution of	sessment. The oust include the include the include the including property of the property of t	nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 560	Will comply.		

Minnesota Department of Health

STATE FORM W1VC11 If continuation sheet 7 of 39

	IT OF DEFICIENCIES		(VO) MULTIPL	F CONSTRUCTION	(VO) DATE	CLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	LETED
			A. BUILDING:		]	. =-
		00922	B. WING		12/3	31/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DRESS CITY S	STATE, ZIP CODE		
INAIVIL OF I	TIOVIDEIT OIT SOLT EIEIT		ESOTA STRI	•		
OSTRAN	IDER CARE AND REH	IAR				
			DER, MN 559			
(X4) ID		TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
1710		,	1710	DEFICIENCY)		
0.500	Continued From no	7	0.500			
2 560	Continued From pa	ge /	2 560			
	significant change I	MDS dated 12/8/15 indicated				
	no toileting program	n or trail, always incontinent of				
	urine and required	extensive assist of one staff				
		sociated urinary care				
		CAA) indicated R3 had urge				
		equired assistance for				
		rineal care. The CAA included,				
		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."					
		essment dated 12/8/15				
		s usually aware of toileting				
	needs and express					
		ssment further indicated R3				
	voided correctly, wi	thout incontinence, less than				
		ne incontinence is in small				
		ssment identified the type of				
	urinary incontinence					
	R3's electronic care	e plan provided by the facility				
		ed R3 had urge incontinent				
	and unable to reach	n bathroom/commode in time				
	related to mobility d	leficit. The care plan directed				
	staff to encourage i	ntake, and report changes in				
	voiding patterns or	appearance in urine. The care				
	plan did not direct s	taff of R3's toileting routines				
	or needs. The care	plan did not reflect the				
		continence (mixed).				
	R3's CNA Assignme	ent Card did not reference an				
		ng schedule or plan.				
		vas 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.				
	J	NA)-A indicated R3 used to put				
		or to her fall to use the				<b> </b>
		plained R3 didn't use the call				
		to use the bathroom and calls				
		we can change her. NA-A				

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stated R3 was always incontinent now. NA-A

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winneso	ita Department of He	aim				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00922	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 9	STATE, ZIP CODE		
		305 MINN	ESOTA STR			
OSTRAN	IDER CARE AND REH	IAR	DER, MN 55			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				· ·		
2 560	•		2 560			
		as offered every 2-3 hours to				
	everybody that need	os ii. on 12/30/15, at 10:30 a.m.				
		f nursing/licensed practical				
		cated residents are not				
		eting plan or schedule and				
		ave toileting programs here,				
		2 hours." LPN-B stated not				
	being sure why there had been an increase in					
		ospitalization for R3. In				
		estion, "If the resident is wet at				
		rval, then what do you do?" In they would change her."				
		on 12/30/15, at 1:48 p.m.				
		a registered nurse) explained				
		eloping an individualized				
		ule. Administrator stated,				
		not have the same toileting				
		ney should be specific to her				
		e schedule should be in their				
	care plan.	el and Bladder Assessment last				
		not meet current standards of				
		ment, care planning, and				
		ndividualized toileting plan to				
		or prevent increase in urinary				
	incontinence.					
	D0 - 11 - 17 11	0 - C - 200				
		y the facility as always				
		ler although the facility lacked ons that included an				
	individualized toileti					
	arriadanzoa tolloti	ng concadio.				
	R6 was admitted to	the facility 4/22/14, with				
		ded diabetes mellitus				
	according to facility	record of admission.				
	The Co. 199   1.1   222	d Do control of the design				
		d R6 on the significant change (MDS), an assessment dated				

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10/21/15, to require extensive assistance of two

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY	
		00922	B. WING		12/3	31/2015
	PROVIDER OR SUPPLIER	305 MINN	DRESS, CITY, S ESOTA STRI DER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 560	staff for toileting, wano toileting program.  Document review of dated 10/29/15, revincontinent of urine program.  Document review of 8/26/14, revealed a incontinence related Approaches included encourage fluid inta apply barrier cream revealed a problem of daily living. Apprextensive assist of provide perineal carbon perineal carbon perineal carbon perineal carbon and time. Not and night, worse received perineal carbon was sometimes were verbal instruct Administrator stated individualized toilet plan.	as always incontinent, and had a.  f R6's urinary assessment realed R6 was always and had no trial of a toileting  f R6's care plan dated problem of urinary and to diabetes sensory deficit. The defended area and and a care plan dated 12/24/15, and the stated to maintain activities to aches included required one to two staff for toileting, and use incontinent brief.  12/29/15, at 9:09 a.m., NA)-B stated had just rining cares which included changing incontinent brief, ith a large amount of urine. It is toileted and voided on the large area after incontinent episodes. It is on a toilet schedule of every and the large were two hour checks.  12/30/15, at 2:30 p.m., at toileting every two hours tions from the nurse.	2 560			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3)			X3) DATE SURVEY COMPLETED	
	00922	B. WING		12/3	31/2015	
NAME OF PROVIDER OR SUPPLIER OSTRANDER CARE AND REM	1AB 305 MINN	DDRESS, CITY, S IESOTA STRE DER, MN 559				
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
directions for toilet Although requested available.  LACK OF SAFETY TAKING A BLOOD MEDICATION:  R23 received anticcare plan interventi to minimize the risk R23 had diagnosis heart disease, periphronic atrial fibrilla according to provide The facility identified change Minimum Expressment dated anticoagulant medical milligrams on Monomilligrams on Monomilligrams the other Document review of administration reconcument of the component of the comp	ed R6's care plan lacked staff schedule.  d, no care plan policies were  PRECAUTIONS WHEN THINNER AND CARDIAC  coagulation medication without ons to direct staff in measures of for bruising.  that included chronic ischemic pheral vascular disease, ation, and hypertension pheral vascular disease, and not decided physician orders dated physician orders for the cation, Coumadin, 2 day and Friday, and 1.5 are five days.  of facility medication produced revealed R23 received m 10/19/15 to 10/31/15; daily 1/21/15-11/30/15; and	2 560				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00922	B. WING		12/3	1/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
OSTRAN	IDER CARE AND REF	ΙΔΗ	ESOTA STR DER, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 560	coumadin use.  During interview on administrator verific direction for use of minimize the risk of Administrator stated instructions for use R23's care plan.  R23 received digox heart rate, without of direct staff in use of R23 had diagnosis heart disease, perigodronic atrial fibrilla according to provide R23's current providers, dated 12/2/for digoxin 125 mic medication if pulse date was 10/19/15.  Document review of administration recording dily as ord 10/31/15; daily 11/1 12/1/15-12/30/15.  Document review of care plan failed to income direction in the control of the	12/31/15, at 9:04 a.m., ed R23's care plan lacked staff coumadin and interventions to f bleeding/bruising. d she expected staff of coumadin to be included in in, a medication to control care plan interventions to	2 560	BEI KIENCI)			
	Document review o	below 50 beats per minute.  If facility undated, untitled g R23, which indicated nurse ore administration of digoxin					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00922	B. WING		12/31/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
OSTRANDER CARE AND REHAB			ESOTA STR DER, MN 559			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 12	2 560			
	and if pulse less than 50, nurse would select blue button at top of computer screen and type in reason digoxin was not administered.					
	licensed practical n hope nurses were of verified the facility li- of daily pulse check digoxin. LPN-A statt would not administe	12/30/15, at 3:20 p.m., urse (LPN)-A stated, "Would checking the pulse." LPN-A acked documented evidence as before administration of ed if pulse below 50, then er digoxin and computer an area to document why the 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.					
	administrator verification monitor pulse were plan. Administrator instructions for use R23's care plan. A	12/31/15, at 9:04 a.m., ed digoxin instructions to not identified in R23's care stated she expected staff of digoxin to be included in dministrator verified the pulse d was not daily pulse checks on of digoxin.				
		12/31/15, at 12:40 p.m., facility lacked policies related plans.				
	facility could review and revise if necess develop and preser regarding importan- the resident's care	THOD OF CORRECTION: The care plan policies/procedures sary, the facility could then at education to staff members ce of fully developing/revising plan, the facility could then nent an auditing system as				

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	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00922	B. WING		12/31/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
OSTRAN	IDER CARE AND REH	AB	ESOTA STR DER, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 560	Continued From pa	ge 13	2 560				
	part of quality assur ensure ongoing con	rance program that would npliance.					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			2/9/16	
		omprehensive plan of care personnel involved in the .					
	by: Based on observation review, the facility factorious limited assistant during meal time for a dining observation to follow the care place.	ent is not met as evidenced on, interview and document ailed to follow the care plan to st of 1 staff and supervision, r 1 of 1 resident (R24) during n, in addition the facility failed an for personal hygiene for 1 bserved to have soiled		Will comply.			
	Findings Include:						
	LACK OF ASSISTA	NCE FOR MEALS:					
	required limited ass	ed 9/22/15 indicated R24 ist of one staff for eating at upervision, with cues to keep					
		imum Data Set (MDS) dated 24 had a brief interview for					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00922	B. WING		12/3	31/2015
	NAME OF PROVIDER OR SUPPLIER  OSTRANDER CARE AND REHAB  OSTRAN  OSTRAN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	mental status score impaired cognition, one for eating and i Alzheimer's disease R24's nurse progresindicated, "Eating. If for eating to feed reability has decrease good appetite, no eproblems."  On 12/30/2015 at 9 to be in the dining remurse (LPN)-C sittin her breakfast. At 9:: the telephone hang rang, LPN-C left R2 the phone and then returned to the dining over to R24 and as bite and proceeded room table and wall positioned right outs 9:30 a.m. LPN-C cawalked around, R24 beverage at this time to her medication of the dining room. At the dining room and to assist her to eat bite of sausage and attempted to provid R24 turned her hea R24 to drink more of drinks of her milk. Left her sausage and R24 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk. Left her sausage and R25 to drink more of drinks of her milk.	e of 0, which indicated severely R24 required limited assist of dentified a diagnoses of e.  ss noted dated 12/8/15 Requires one aide for assist esident for all meals eating ed. Usually eats 75%, has ating concerns or swallowing  :09 a.m., R24 was observed oom with licensed practical ng by R24 assisting her to eat	2 565			
	took the cup and st	arted to independently drink of the attention of a surveyor				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:	<del></del>		
		00922	B. WING		12/31/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OOTDAA	IDED CADE AND DEL	305 MINN	IESOTA STRI	EET		
USTRAN	IDER CARE AND REF	OSTRANI	DER, MN 559	961		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 15	2 565			
	medication pass. L table with her plate glasses sitting in fre plate around on the of the cups. There in the dining room a medication cart out preparing medication picked up pieces of back down on her p with the food, R24 sausage and place staff member prese time. At 9:42 a.m. L room to administer medication. R24 co of her plate and pla At 9:44 a.m. LPN- go to the medicatio in the dining room. of her clothing prote table as it was still 9:45 a.m. LPN-C sa LPN-C used a fork the cups and starte and offered her and accepted the bite of drink of milk and R food. R24 picked u and took a bite inde another bite of grille accepted a drink of accepted took a drink indepe another bite of food 9:55 a.m. LPN-C as	or had time to watch a PN-C left R24 sitting at the of food and three beverage ont of her. R24 moved the table and placed food in one was no staff member present at this time. LPN-C was at the side of the dining room, ons for another resident. R24 if her food and placed them plate appearing to be playing picked up a piece of her dit in her mouth. There is no ent in the dining room at this LPN-C reentered the dining another resident their entinued to pick up the food office it back down on her plate. C again left the dining room to n cart and there was no staff R24 started to fold the bottom ector on top of the dining room fastened around her neck. At at back down by R24 and to remove food from one of d offering R24 drinks of milk other bite of her sandwich. R24 if the food. Offered resident 24 accepted another bite of p a piece of the grilled cheese ependently. R24 accepted and milk. At 9:51 a.m. R24 wite of her grilled cheese ted up one of her cups and ndently. R24 accepted at 3:52 a.m., 9:53 a.m. and sked R24 if she would like a cked on the kitchen door and				

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asked for a soft cookie for R24. LPN-C

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00922	B. WING		12/3	1/2015
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OSTRAND	ER CARE AND REH	IAB	ESOTA STRI DER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
the second of th	sat the plastic wrap proceed to clean a 10:01 a.m. LPN-C wasked her how the plastic the garbage, left the medication cart. At the dining room and the 10:06 a.m. LPN-dining room to the control of the co	kie from the plastic bag and per on the table. LPN-C table top in the dining room. At walked back over to R24, cookie was, removed her plate cookie wrapper threw them in edining room and at the 10:03 a.m. LPN-C reentered dasked R24 if she was done. C wheeled R24 out of the day room.  119 a.m. LPN-B stated R24 st of one to eat. was able to hold her own glass and was able to eat finger. LPN-B stated her care plan ime R24 required assist of 1 at supervision with cues. LPN-B ion was staff should sit with eleted her meal. LPN-B verified ing the care plan to provide iteal times and supervision with	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00922	B. WING		12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
OSTRAN	IDER CARE AND REH	IAR	ESOTA STRE DER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 17	2 565			
	beverages from her evening meal. She was observed to have brown debris underneath four fingers on her left and right hands.					
	care of her fingerna	:27 p.m., R5 stated staff took ills once a week on her bath was blind and has a hard time				
	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.					
	through an observa underneath "the ma stated the condition acceptable and veri LPN-B stated staff wash her hands aft finger nails to ensur verified R5's care p nail care, but stated to be a part of resid	:13 p.m., LPN-B verified tion R5 had brown debris ajority of her nails." LPN-B of her nails was not ified they needed to be clean. needed to clean R5's nails and er meals and inspect her re they were clean. LPN-B lan did not specifically address if she would consider nail care lent grooming. LPN-B verified not followed for R5 to appear				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00922		B. WING		1/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 12/0	172010	
OSTRAN	IDER CARE AND REF	IAR	ESOTA STR DER, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	Continued From pa	ge 18	2 565				
	well groomed.						
	A care plan policy was requested and was not provided.						
	facility could review and revise if necess develop and preser regarding importan care plan, the facilit implement an audit	THOD OF CORRECTION: The care plan policies/procedures sary, the facility could then at education to staff members are of following the resident's ty could then develop and ing system as part of quality a that would ensure ongoing					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 860	MN Rule 4658.0520 Proper Nursing Car	O Subp. 2 F. Adequate and re; Hands-Feet	2 860			2/9/16	
	proper care. The c adequate and prop E. per care and att	or determining adequate and riteria for determining er care include: ention to hands and feet. nails must be kept clean and					
	by: Based on observati review, the facility f	ent is not met as evidenced on, interview and document ailed to ensure clean nails for 5) reviewed for activities of		Will comply.			
	Finding Include:						
	R5's quarterly Minir	num Data Set (MDS) dated					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00922	B. WING		12/31/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
OSTRAN	IDER CARE AND REH	IAR	ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 860	10/26/15, identified of one person for 12/29/2015 at 6 be sitting at dining reson her left at the served to have be fingers on her left at the care of her fingern day and stated she seeing.  On 12/30/2015 at 1 residents' nails were bath days. NA-C stand dirty nails staff NA-C was asked to the surveyor. NA-C disgusting they are used her fingers to food underneath her some of R5's nails get underneath her 12/30/2015 at 2:12 with nursing assistation have brown debroth hands. NA-C "Yucky and needed she was going to as to clean them tonig."  On 12/30/2015 at 2 nurse (LPN)-B verification for person for p	R5 required extensive assist ersonal hygiene and identified d vision. The care plan dated 5 had macular degeneration vision with grooming.  :24 p.m., R5 was observed to room table drinking her revening meal. She was rown debris underneath four and right hands.  :27 p.m., R5 stated staff took alls once a week on her bath was blind and has a hard time is to be cleaned them as needed. To observe R5's fingernails with stated hers are, "Probably every day." NA-C stated R5 eat and stated she would get er fingernails. NA-C stated were so curved it was hard to nails to clean them. On p.m., during an observation ant (NA)-C, R5 was observed is under her fingernails were, to be cleaned." NA-C stated sk one of the evening shift girls ht.  :13 p.m., licensed practical fied through an observation R5	2 860			
	On 12/30/2015 at 2 nurse (LPN)-B verif had brown debris u	:13 p.m., licensed practical				

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00922	B. WING		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OSTRAN	IDER CARE AND REH	AB	ESOTA STR DER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	was not acceptable be clean. LPN-B sta R5's nails and wash inspect her finger na LPN-B verified R5's address nail care, be nail care to be a parverified R5's care plappear well groome. On 12/30/2015 at 3 stated she expected maintained and cleastaff should be was ensuring clean finger A policy was requestly giene for resident SUGGESTED MET The DON could insta to their responsitive residents with assist to facility policy. The ensure the care is be and take action as in the control of the control of the control of the care is be and take action as in the care is be and take action as in the care is be and take action as in the care is be and take action as in the care is	and verified they needed to ated staff needed to clean her hands after meals and ails to ensure they were clean. It care plan did not specifically out stated she would consider out of resident grooming. LPN-B lan was not followed for R5 to ed.  129 p.m., the administrator of dresident's finger nails to be aned. The administrator stated hing residents hand and ernails daily.  15 Sted on ensuring personal the and was not provided.  16 HOD OF CORRECTION: 17 Up that staff are re-inserviced billity to provide dependent thance with nail care according to being provided as indicated	2 860			
2 910	MN Rule 4658.0525 Incontinence	5 Subp. 5 A.B Rehab -	2 910			2/9/16
	have a continuous programment to red unnecessary use of	nce. A nursing home must program of bowel and bladder luce incontinence and the catheters. Based on the ident assessment, a nursing that:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:			K3) DATE SURVEY COMPLETED	
		00922	B. WING		12/3	1/2015
	PROVIDER OR SUPPLIER	305 MINN	DRESS, CITY, SIESOTA STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	A. a resident w without an indwellin unless the resident that catheterization B. a resident whereceives appropriat prevent urinary trace	ge 21 ho enters a nursing home g catheter is not catheterized s clinical condition indicates was necessary; and no is incontinent of bladder e treatment and services to t infections and to restore as er function as possible.	2 910			
	by: Based on observati review the facility fa implement an indivi increase in urinary i residents (R3) revie Findings include: R3 was hospitalized following a fall with decrease of mobility assistance for toilet R3's urinary incontine However, the facility in urinary incontine However, the facility in urinary incontine individualized toileti restore bladder funct the highest attainat R3's significant cha 8/18/15 indicated no Brief Interview for N 14, required extens member for toileting program, and was of urine. R3's Significant cha	ent is not met as evidenced on, interview, and document alled to evaluate and dualized toileting plan after an incontinence for 1 of 2 ewed for urinary incontinence.  If from 9/2/15 to 9/8/15 femur fracture resulting in y and an increase in staffing. Following hospitalization, nence increased from ent to always incontinent. Y failed to assess the increase nce and develop an ng plan in an attempt to oction to the previous level or ole level of bladder function. Inge Minimum Data Set dated to cognitive impairment with a Mental Status (BIMS) score of ive assist from one staffing, did not have a toileting occasionally incontinent of lange MDS dated 9/15/15 ve impairment with a BIMS		Will comply.		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMP	LETED
		00922	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OCTRAL	IDED CADE AND DEL	305 MINN	ESOTA STR	EET		
USTRAN	IDER CARE AND REF	OSTRANI	DER, MN 559	961		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	staff members for t program, and was f R3's fourteen day M no cognitive impairs required extensive for toileting, did not was always incontin R3's significant cha indicated no cogniti score of 15, require staff member for to program, and was a The associated urin (CAA) indicated R3 required assistance care. The CAA inclu- often but will alert s Incontinence produ- pericare is complet episodes. Will deve	ange MDS dated 12/8/15 live impairment with a BIMS ed extensive assist from one ileting, did not have a toilet always incontinent of urine. hary care assessment area had urge incontinence and for transferring and perineal uded, "She is incontinent quite staff to need to use the toilet. licts are managed by staff and ed after incontinence				
	resident is usually a expresses accepta. Assessment further without incontinence the incontinence is assessment identification incontinence as mix R3's record did not evaluation of the de R3's electronic care on 12/30/15 indicat and unable to reach related to mobility of staff to encourage if voiding patterns or care plan did not did routines or needs.	aware of toileting needs and nce of incontinence. r indicated R3 voided correctly, e, less than once per day and in small amounts. The led the type of urinary				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00922	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OSTRAN	IDER CARE AND REH	IAR	ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	reflect the assesser indicated on the blather record did not was revised to reflect changes from occasin continent.  R3's CNA Assignment individualized toileting individualized always individualized always individualized or plan afformation on her call light prior restroom. NA-A ex light at all anymore when she is wet so stated R3 was always indicated toileting we everybody.  During an interview assistant director on urse ADON LPN-E assessed for a toile stated, "We don't him we just offer every being sure why the incontinence post him the question, "If the hour interval, then we LPN-B stated, "The During an interview stated that since shidoes not ask to get anymore. R3 state her pants and then	d type of incontinence that was adder assessment (mixed). show evidence the care plan ect the bladder function sionally incontinent to always ent Card did not reference an ang schedule or plan. The documentation	2 910			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00922 B. WING 12/3		12/3	1/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
OSTRAN	IDER CARE AND REH	IAR	ESOTA STR			
	OLIMANA DV. OTA		DER, MN 559			0.50
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 24	2 910			
	out of fear of falling comfortable. R3 incomfortable. R3 incomfortable. R3 incomfortable. R3 incomfortable. R3 incomfortable. R3 was bedside concommended by the toilet at all, she the reason for refusive walk and use a walk staff lift and put her R3 was not on a toil aware of any interval amount of urinary in During an interview administrator (also the process for device toileting plan/sched "Everybody should plan or schedule, the needs." Stated, the care plan. Facility policy Bower revised 3/07 does in practice for develop implementation of it improve, maintain, or such as the state of the process of the process of the process for develop implementation of it improve, maintain, or such as the such as the process of	again and was not dicated an awareness of urge been offered alternatives mmode or bedpan. on 12/30/15, at 1:07 p.m. s more incontinent than prior d R3 does not want to go to refuses. NA-B did not know sals. NA-B explained R3 could ker but R3 would rather have on the toilet. NA-B indicated leting schedule and was not entions to decrease the				
	incontinence.	HOD OF CORRECTION: The				
	facility could review review their policies to include individua schedules/plan/prod develop assessmen on how to assess, i individualized toileti facility could then d	the state requirements, s/procedures and revise them lized toileting gram, the facility could then hts and tools and educate staff mplement, and maintain an ng plan for all residents. The evelop and implement an part of the quality assure				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED
		00922	B. WING		12/3	1/2015
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
OSTRAN	DER CARE AND REH	IAR	ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 25	2 910			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi		21015			2/9/16
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all				
	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.			Will comply.		
	Findings include:					
	a.m., dietary aide (I in the dishwasher wash c dishwasher dial, who checked the rinse of 105 degrees. DA-A strip to monitor che per million (ppm). I 12/28/15, were revidishwasher rinse cydegrees. During in manager verified the	chen tour on 12/28/15, at 8:45 DA)-A washed a load of dishes At that time, DA-A checked the ycle temperature on the nich read 102 degrees, and cycle on the dial, which read A used a chlorine test paper micals which read 100 parts Dishwasher logs for 12/1/15 to ewed, which revealed ycle temperatures 100-120 terview at that time, dietary the temperature log were the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. BOILBING.			
		00922	B. WING		12/3	31/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
OSTRAN	NDER CARE AND REI	1AB	ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	rinse cycle tempera stated she was awatemperatures. Diet reported the low terperatures and the several times. Diet expected the dishwas a land to degrees. Dietary in dishwasher was a land temperature of the cycle, with wash 10 degrees. During in manager stated hat temperatures, possimaintenance departemperatures in resist that time, dietary chemical solution of the cycle with the temperature maching interview or dietary manager verinse temperature in the temperature with the temperature in the temperatures in the temperature in the temperature in the temperature in the temperature in the temperatures and following identified: 8/16/15-breakfast in the cycle in the	atures. Dietary manager are of the low dishwasher tary manager stated she had imperatures to administration ary manager stated she washer wash temperature to be the rinse temperature to be 120 manager verified the ow temperature dishwasher.  Is on 12/28/15, at 10:25 a.m., in one dishwasher cycle and in temperatures on the second of degrees and rinse 105 terview at that time, dietary differs noticed low dishwasher sibly in 9/2015, when interest the dishwasher was liquid sanitizer for low mes.  In 12/28/15, at 10:35 a.m., perified 8/16/15, dishwasher was 135 degrees and verified ad been 120 and below since of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the period of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15. Dishwasher rinse of the cycle logs were reviewed for 1/28/15.	21015			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00922	B. WING		12/3	1/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE			
OSTRAN	IDER CARE AND REH	IAR	ESOTA STR DER, MN 55				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21015	Continued From page 27		21015				
	recordings at 120 degrees, and 226 rinse recordings were 100 to 115 degrees.						
	revealed signage of following information Ecolabminimum with vision and provided by DA During interview at verified no docume administration of low During interview on administrator verified dishwasher temperature of nursing signature of nursing signature of signature of the dishwasher the following direction temperatures-washer signature of the dishwasher the following direction temperatures-washer signature of the dishwasher temperatures-washer signature of the dishwasher the following direction temperatures of the dishwasher the following direction the dishwasher temperatures of the dishwasher the following direction the dishwasher temperatures of the dishwasher the following direction the dishwasher the dishwasher the following direction the dishwasher the following direction the dishwasher the d	vash120 degrees; minimum The signage temperatures -A and dietary manager. that time, dietary manager nted evidence of notifying w dishwasher temperatures.  12/28/15, at 11:22 a.m., ed she was aware of the low atures.  12/28/15, at 11:43 a.m., stated facility had no otoms since 8/16/15.  f manufacturer's instructions provided by facility, revealed ons: operating (minimum) 120 degrees anitizing rinse (min) 120					
	Equipment" policy of following: #5." The wash wate 120-140 degrees;"	f facility "Dishwashing and dated 10/18/11, revealed the er temperature shall be within ratio shall be within 50-100."					
	facility could review regarding safe dish temperatures based	THOD OF CORRECTION: The their policies and procedures washer operating d off the manufacturer's and guidelines. The facility					

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED
			A. BOILDING.			
		00922	B. WING		12/3	31/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
OSTRAN	IDER CARE AND REH	ΙΔΗ	ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 28	21015			
		a system for notification and nent in a timely manner.				
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21375	5 MN Rule 4658.0800 Subp. 1 Infection Control; Program		21375			2/9/16
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.					
	by: Based on observation review, the facility for glucometer was continuous the manufacturer's disinfecting re-usab potential to effect 1 the same glucomet Findings include: R7 was observed of licensed practical indonned gloves, and reading from R7 us Following the process medication cart, rub Germicidal Disposation that the glucomet where it air dried with interview with LPN-procedure, LPN-C smanufacturer's direction of the glucomet with the procedure, LPN-C smanufacturer's direction that the glucometer is a single procedure, LPN-C smanufacturer's direction that the glucometer is a single procedure, LPN-C smanufacturer's direction of the glucometer is a single procedure.	ent is not met as evidenced on, interview, and document ailed to ensure a multi-use rectly disinfected according to recommendations for ole equipment this had the of 10 residents (R7) who used er for checking blood sugars.  In 12/20/15 at 11:50 a.m. when urse (LPN)-C washed hands, d obtained a blood sugar ing a multi-use glucometer. Edure LPN-C returned to the obed a PDI Super Sani-Cloth able Wipe on the glucometer eximately five seconds, and eter on the medication cart ithin seconds. During an C directly following the stated an unawareness of the oction on the container the to be continuously wet for two		Will comply.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			TE SURVEY MPLETED	
			A. BUILDING:				
		00922	B. WING	····	12/3	31/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
OSTRAN	DER CARE AND REF	IAB	ESOTA STR DER, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21375	disinfecting include remain wet for two wipes to assure sur two minute contact Facility procedure (Disinfecting (not da glucometers must buse, in between parblood or body fluids (purple top)-CONT/minutes."  SUGGESTED MET director of nursing oneed to follow curremulti use glucometers.	mal disinfectants  ruction on the container for d, allow treated surface to minutes and use additional faces have the continuous full time.  Glucometer Cleaning and ated) indicated, "All be cleaned after each patient tients, and after contact with a Wipe down with Sani-Coths ACT TIME for purple wipes is 2  THOD OF CORRECTION: The could in-service all staff on the ent guidelines for disinfecting a	21375				
21426	(a) A nursing home maintain a comprel infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu	A.04 Subd. 3 Tuberculosis ntrol  e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease pation (CDC), Division of nation, as published in CDC's fality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance	21426			2/9/16	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00922	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
OSTRAN	IDER CARE AND REH	ΙΔΗ	ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 30	21426			
	regarding impleme	ntation of the guidelines.				
		ance with this subdivision must				
	by: Based on interview facility failed to prove ducation to all employees received failed to perform TE (IGRA) prior to have employee (EE-1, 2, sample. In addition symptom screeners residents (R16, 7, 2 into the facility. Findings include: Employee TB contremployee (EE)-1's of 4/1/14. The recosymptom screen. To step TST was adminated resident contact revealed the secondary after the firs EE-2's records reflect the record indicate administered after the contact on 4/1/15. Employee records 12/23/25, EE-4 with with a hire date of Stephen and services and servic	and document review, the vide annual tuberculosis (TB) ployees, failed to ensure all d TB symptom screeners and 3 skin test (TST) or blood test ing resident contact for 5 fo 5 3, 4 & 5) reviewed in the the facility failed to provide and TB test to 4 of 4 27, and 900) newly admitted ol and prevention program: records reflected a hire date rd lacked evidence of a TB he record indicated the first inistered after the employee at on 4/7/15. The record also d step TST was administered at step on 4/14/15. The record also d the first step TST was administered at the employee had resident for EE-3 with a hire date of a hire date of 7/7/15, and EE-5 0/2/15 all lacked evidence stered and evidence TB		Will comply		

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Millinesc	ita Department of He	aim				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00922	B. WING		10/0	14/0015
		00922	B. W		12/3	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		305 MINN	ESOTA STR	FFT		
OSTRAN	IDER CARE AND REH	IAR	DER, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	-	(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
iAd		,	IAG	DEFICIENCY)		
21426	Continued From pa	ge 31	21426			
	cymptome coroono	re were performed				
	symptoms screene					
		l and prevention program:				
		record lacked evidence of a				
		n. The record indicated the				
	•	as due on 8/20/15; the record				
		econd step was administered.				
		record lacked evidence of a				
		ner. The record indicated the				
		administered on 10/2/15 and				
		T was administered less than				
	14 days later on 10	/14/15.				
	R27's The immuniz	ation record lacked evidence				
	of a TB symptom so	creen. The record reflected the				
	first step TST was a	administered on 11/4/15 and				
		ecord did not indicate the				
		ation. The record further				
	reflected the secon	d step was administered less				
	than 14 days later of					
		on record lacked evidence of a				
		ner. The immunization record				
	, ,	tep TST was administered on				
		was not read. The record				
	T	as re-administered on				
		negative on 12/20/15 however,				
		millimeters of induration. The				
		cted the second step was				
		days later on 12/25/15.				
		on 12/20/15, at 1:52 p.m.,				
		(DON) stated there indicated				
		a system in place during the				
		to ensure TB screens were				
		ON stated they were still				
		employee orientation				
	process.	ampleyee engined TD advastice				
		employee annual TB education				
		the facility administrator on				
		vas returned to the surveyor				
		note, "no dates that I can find"				
	for education. The i	note also indicated no				

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symptom screeners for residents were located.

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00922	B. WING		12/31/20	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	1 12/9	7,2010
OSTRAN	DER CARE AND REH	IAR	ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 32	21426			
	Care Workers not of workers should recutuberculosis that is particular occupation conducted before in for additional training periodically (once a A facility policy/producted before in the second periodically (once a Suggested was required by the second periodically could audit as workers and the second periodically could are second periodically could are second periodically could periodically periodically could periodically co	cedure for resident TB lested and not received.  THOD OF CORRECTION: The last resident and employee				
	current. The facility policies/procedures of residents and rev for employees base recommendations a could also review the ensure all staff are	for TB testing and screening view policies and procedures				
21805	Residents of HC Fa Subd. 5. Courteouresidents have the courtesy and respe	.651 Subd. 5 Patients & ac.Bill of Rights us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a	21805			2/9/16
	by: Based on observati	ent is not met as evidenced on and interview the facility resident (R24) with dignity		Will comply.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00922	B. WING		12/3	1/2015
OSTRANDER CARE AND REHAB 305 MINN		DRESS, CITY, S ESOTA STRI DER, MN 559			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
to anyone in the arunderneath R24 wand failed to provide for R24.  Findings Include:  INCONTINENCE IN WHEELCHAIR AREA:  R24, was observed located in the common the television sitting plastic incontinent absorb urine) place cushion of the whomas residents sitting in time.  On 12/29/2015 at observed in the common in a wheelchair with pad placed undernoresidents sitting in the common in a wheelchair with pad placed undernoresidents sitting in the common in a wheelchair with pad placed undernoresidents sitting in R24's quarterly Min 12/8/15, revealed in mental status scorimpaired cognition	age 33 Int product was partially visible the and been placed hile seated in her wheelchair de a dignified dining experience of the adjusted dining experience of the adjusted dining experience of the facility near gin a wheelchair with a visible chuck pad (a pad used to red underneath her on the relchair. There were five other the same common area at this of the plastic incontinent chuck reath her. There were five other the same common area.  7:03 p.m. R24 continued to be mmon area of the facility sitting the plastic incontinent chuck reath her. There were five other the same common area.  7:03 p.m. R24 continued to be mmon area of the facility sitting the plastic incontinent chuck reath her. There were five other the same common area.  7:03 p.m. R24 continued to be mmon area of the facility sitting the plastic incontinent chuck reath her. There were five other the same common area.	21805			

6899

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00922	B. WING		12/3	31/2015
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  305 MINNESOTA STREET  OSTRANDER, MN 55961						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21805	On 12/29/2015 at 7 nurse (LPN)-B state pad should not hav R24 in her wheelch brief for incontinent pad was a dignity is p.m., LPN-B verified plastic incontinent of underneath R24 in sitting in her wheelch facility which was viresidents.  On 12/29/2015 at 7 verified through obsincontinent chuck pR24 in her wheelch this would not be so here at the facility. was a dignity issue was astounded and happen again.  On 12/29/2015 at 7 was observed to tal gait belt was placed required an assist of stand. The plastic in removed from the wall a cloth incontinent oback down in the wall (NA)-D stated they wheelchair as R24 soaked through her on 12/29/2015 at 7 stated it would not be incontinent chuck powerified the cloth children in the cloth children	ge 34  :16 p.m., licensed practical ed a plastic incontinent chuck be been placed underneath air. LPN-B stated R24 wore a se and stated the visible chuck issue. On 12/29/2015 at 7:17 d through observation the chuck pad was placed her wheelchair and she was chair in a common area of the sited by staff, families, and  :18 p.m., the administrator servation the plastic ad was placed underneath air. The administrator stated omething they would practice The administrator stated this for the R24 and stated she I would make sure that did not see R24 back to her room. A I around R24's waist and she of two nursing assistants to incontinent chuck pad was wheelchair, was replaced with chuck pad and R24 was sat heelchair. Nursing assistant placed the chuck in her was incontinent and she had brief and her pants earlier.  :32 p.m., the administrator be appropriate to use a cloth ad in R24's wheelchair and uck pad would also be a ident. On 12/29/2015 at 7:35	21805			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00922			12/31/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		.==
OSTRAN	IDER CARE AND REH	IAB	ESOTA STR DER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 35	21805			
		tor verified through as sitting on a cloth incontinent heelchair in the hallway.				
	stated R24 had soa and the cushion in administrator stated her the incontinent wheelchair to prote from the cushion. T was still not a good incontinent pads in	:38 p.m., the administrator aked through her brief earlier her wheelchair was wet. The dithe nursing assistants told products were placed in R24's ct her clothing from getting wet the administrator stated this reason to place the chuck R24's wheelchair. The dishe educated the nursing y for the resident.				
	to be sitting in the h	:46 p.m., R24 was observed nallway in the wheelchair with a nent chuck pad underneath				
		24 RECEIVED ADEQUATE CKED A DIGNIFIED DINING				
	a.m. located in the practical nurse (LPI her to eat her break the telephone hang rang, LPN-C left R2 the phone and then returned to the dinin over to R24 and as bite and then procedining room table a which was located 9:30 a.m. LPN-C cawalked around the	ing on the dining room wall 24 sitting at the table to answer left the dining room. LPN-C ng room at 9:28 a.m. walked ked if she would like another eded to leave R24 at the nd walk to the medication cart outside of the dining room. At ame back into the dining room,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BOILDING.			
	00922	B. WING		12/3	1/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
OCTUANDED CADE AND DEL	305 MINN	ESOTA STR	EET		
OSTRANDER CARE AND REF	OSTRAND	DER, MN 55	961		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805 Continued From pa	ige 36	21805			
9:31 a.m. LPN-C accart positioned right 9:31 a.m LPN-C rest down by R24 accordink of apple juice resident another bit away. LPN-C encorder fluids. R24 accorder fluids. R24 sitting at the tathree beverage glamoved the plate are flood in one of the comember present in LPN-C was at the redining room, preparesident. R24 picked placed them back of hands, R24 picked placed it in her morder fluids. R24 picked placed it in	gain went to the medication of outside of the dining room. At eentered the dining room and and offered to assist her to eat cepted a bite of sausage and a cepted a bite of sausage and a cepted drinks of her milk. There is no staff member and pieces of her sausage and lently drink her plate of food and sees sitting in front of her. R24 ound on the table and placed cups. There was no staff the dining room at this time. There is no staff member and placed out pieces of her sausage and oth. There is no staff member and placed on her plate with her up a piece of her sausage and oth. There is no staff member are dup in the dining room to resident their medication. R24 per the dining room to resident their medication. R24 per the food off of her plate and on her plate. At 9:42 red the dining room to resident their medication. R24 per the food off of her plate and on her plate. At 9:44 a.m. the dining room to go to the dather was no staff in the tarted to fold the bottom of her on top of the dining room table and around her neck. At 9:45 ock down by R24 and LPN-C ove food from one of the cups and placed drinks of milk and	21805			

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STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00922	B. WING		12/3	1/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
OSTRAND	DER CARE AND REH	AB	ESOTA STRI DER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETE DATE
	accepted the bite of drink of milk and R2 food. R24 picked up and took a bite inde another bite of grille accepted a drink of accepted another bis sandwich. R24 pick took a drink indeperanter bite of food 9:55 a.m. LPN-C as cookie. LPN-C known asked for a soft cookie unwrapped the cool sat the plastic wrapproceed to clean a factor of food then went to a.m. LPN-C vasked her how the coff food then went to a.m. LPN-C reenter R24 if she was done wheeled R24 out of room.  R24's quarterly Minitalized R24's quarterly Minitalized Cognition, one for eating and in Alzheimer's disease R24's care plan dat required limited assitimes, but at least son task.  R24's nurse progressindicated, "Eating. Factor of the side of	bite of her sandwich. R24 if the food. Offered resident 24 accepted another bite of 25 a piece of the grilled cheese 35 pendently. R24 accepted 36 de cheese from the nurse and 37 milk. At 9:51 a.m. R24 38 ite of her grilled cheese 38 ed up one of her cups and 38 ndently. R24 accepted 39 at 9:52 a.m., 9:53 a.m. and 39 sked R24 if she would like a 30 sked R24 if she would like a 30 sked on the kitchen door and 30 sked R24. LPN-C 31 kie from the plastic bag and 32 per on the table. LPN-C 33 table top in the dining room. At 36 valked back over to R24, 37 cookie was, removed her plate 38 the medication cart. At 10:03 38 the dining room and asked 39 the dining room to the day 30 imum Data Set (MDS) dated 30 at 10:06 a.m. LPN-C 31 the dining room to the day 32 imum Data Set (MDS) dated 33 at 10:06 a.m. LPN-C 34 the dining room to the day 36 at 10:06 a.m. LPN-C 37 the dining room to the day 38 at 10:06 a.m. LPN-C 39 the dining room to the day 30 at 10:06 a.m. LPN-C 31 the dining room to the day 31 at 10:06 a.m. LPN-C 32 the dining room to the day 33 at 10:06 a.m. LPN-C 34 the dining room to the day 36 at 10:06 a.m. LPN-C 37 the dining room to the day 38 at 10:06 a.m. LPN-C 39 the dining room and asked 30 at 10:06 a.m. LPN-C 30 at 10:06 a.m. LPN-C 31 the dining room and asked 32 at 10:06 a.m. LPN-C 33 at 10:06 a.m. LPN-C 34 at 10:06 a.m. LPN-C 35 at 10:06 a.m. LPN-C 36 at 10:06 a.m. LPN-C 37 at 10:06 a.m. LPN-C 38 at 10:06 a.m. LPN-C 39 at 10:06 a.m. LPN-C 30 at 10:06 a.m. LPN-C 30 at 10:06 a.m. LPN-C 31 at 10:06 a.m. LPN-C 32 at 10:06 a.m. LPN-C 33 at 10:06 a.m. LPN-C 34 at 10:06 a.m. LPN-C 35 at 10:06 a.m. LPN-C 36 at 10:06 a.m. LPN-C 37 at 10:06 a.m. LPN-C 38 at 10:06 a.m. LPN-C 39 at 10:06 a.m. LPN-C 30 at 10:06 a.m. LPN-C 30 at 10:06 a.m. LPN-C 30 at 10:06 a.m. LPN-C 31 at 10:06 a.m. LPN-C 32 at 10:06 a.m. LPN-C 33 at 10:06 a.m. LPN-C 34 at 10:06 a.m. LPN-C 35 at 10:06 a.m. LPN-C 36 at 10:06 a.m. LPN-C 37 at 10:06 a.m. LPN-C 38 at 10:06 a.m. LPN-C 39 at 10:06 a.m. LPN-C 30 at 10:06 a.m. LPN-C 30 at 10:06 a.m. LPN-C	21805			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00922	B. WING		12/3	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OSTRAN	IDER CARE AND REH	ΔR	ESOTA STR DER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21805	ability has decrease good appetite, no e problems."  On 12/31/2015 at 9 was to receive assist LPN-A stated R24 vindependently drink food independently indicated for meal titimes, but at least stated her expectat R24 until she comp R24 did not receive when the nurse did meal and R24 was food.  On 12/31/2015 at 9 stated she expected residents in the diniverified R24 was not dignity when she was the observed dining.  An untitled and undindicated, "We will to visitors with respect SUGGESTED MET facility could review providing dignified or review/implement passuring dignified congoing education accompliance.  TIME PERIOD FOR	ed. Usually eats 75%, has ating concerns or swallowing  19 a.m. LPN-B stated R24 st of one to eat.  It was able to hold her own glass and was able to eat finger.  LPN-B stated her care plan ime R24 required assist of 1 at upervision with cues. LPN-B ion was staff should sit with leted her meal. LPN-B verified a dignified dining experience not supervise R24 during the observed to play with her  29 a.m., the administrator d staff to provide attention to ng process. The administrator of treated with respect and as having her breakfast during	21805			
	days.					

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