



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
March 24, 2025

Administrator  
Ostrander Care and Rehab  
305 Minnesota Street  
Ostrander, MN 55961

RE: CCN: 245464  
Cycle Start Date: January 29, 2025

Dear Administrator:

On March 19, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

This includes corrections for survey's exiting on 2/20/25 and 1/29/25.

Feel free to contact me if you have questions.

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Orville L. Freeman Building | HRD 3A 3rd Floor  
PO Box 64900  
625 Robert Street North  
St. Paul, MN 55155  
Office: 651-201-4384  
Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)



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Electronically delivered  
March 24, 2025

Administrator  
Ostrander Care and Rehab  
305 Minnesota Street  
Ostrander, MN 55961

Re: Reinspection Results  
Event ID: NZDP12

Dear Administrator:

On March 3, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 29, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Holly Zahler'.

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Orville L. Freeman Building | HRD 3A 3rd Floor  
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*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
February 13, 2025

Administrator  
Ostrander Care And Rehab  
305 Minnesota Street  
Ostrander, MN 55961

RE: CCN: 245464  
Cycle Start Date: January 29, 2025

Dear Administrator:

On January 29, 2025, a survey was completed at your facility by the Minnesota Department of Health, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response  
Health Regulation Division  
Minnesota Department of Health  
Rochester District Office  
3425 40th Avenue NW, Suite 115  
Rochester, MN 55901  
Email: [Lisa.Krebs@state.mn.us](mailto:Lisa.Krebs@state.mn.us)  
Office (507) 206-2728

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

If substantial compliance with the regulations is not verified by April 29, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by July 29, 2025 (six months after the identification of noncompliance), your provider agreement will be terminated. 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.

**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.**

#### **INFORMAL DISPUTE RESOLUTION (IDR)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

#### **INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

Ostrander Care And Rehab

February 13, 2025

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A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Zahler".

Holly Zahler, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Orville L. Freeman Building | HRD 3A 3rd Floor  
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February 13, 2025

Administrator  
Ostrander Care and Rehab  
305 Minnesota Street  
Ostrander, MN 55961

Re: State Nursing Home Licensing Orders  
Event ID: NZDP11

Dear Administrator:

The above facility was surveyed on January 28, 2025, through January 29, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html). The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Ostrander Care and Rehab

February 13, 2025

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

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

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

**Lisa Krebs, Regional Operations Supervisor, Rapid Response**

**Health Regulation Division**

**Minnesota Department of Health**

**Rochester District Office**

**3425 40th Avenue NW, Suite 115**

**Rochester, MN 55901**

**Email: [Lisa.Krebs@state.mn.us](mailto:Lisa.Krebs@state.mn.us)**

**Office (507) 206-2728**

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 feel free to call me with any questions.



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

PO Box 64900

625 Robert Street North

St. Paul, MN 55155

Office: 651-201-4384

Email: [holly.zahler@state.mn.us](mailto:holly.zahler@state.mn.us)

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

PRINTED: 02/24/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245464</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/29/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>OSTRANDER CARE AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>305 MINNESOTA STREET</b> <b>OSTRANDER, MN 55961</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  On 1/28/25 and 1/29/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.  The following complaint was reviewed: H54645760C (MN110024)with a deficiency cited at F656 and F660.  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.  Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		2/21/25	

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

TITLE

(X6) DATE

Electronically Signed

02/21/2025

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

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F 656	<p>Continued From page 1</p> <p>or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to ensure comprehensive care plans were developed to implement care and services for oxygen therapy due to obstructive sleep apnea (OSA), for 1 of 1 residents (R1) reviewed</p>	F 656	<p>It is the practice of Ostrander Care and Rehab to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to</p>	

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F 656	<p>Continued From page 2 for discharge.</p> <p>Findings include:</p> <p>R1's Telephone Order dated 4/8/24, identified to start nocturnal oxygen at 1 liter per nasal canula for OSA and anxiety.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 12/2/24, identified R1's cognition to be intact and diagnoses of obstructive sleep apnea (a sleep disorder characterized by repeated episodes of complete or partial blockage of the upper airway during sleep, leading to reduced or absent breathing which can result in low oxygen levels). Further identified R1 used oxygen while a resident.</p> <p>R1's care plan was reviewed and did not identify R1's diagnoses of sleep apnea nor did it identify the medical provider ordered intervention to receive oxygen therapy. Further did not identify interventions to to manage/treat the disorder with goals of care.</p> <p>During an interview on 1/29/25 at 11:57 a.m., nursing assistant (NA)-A stated R1 would use her oxygen whenever she would sleep, she thought she used 2 liters at night.</p> <p>During an interview on 1/29/25 at 1:38 p.m., licensed practical nurse (LPN)-A stated R1 used her oxygen while she slept, R1 would get very anxious about sleeping, and quite hard to deal with if she didn't have her oxygen.</p> <p>During an interview on 1/29/25 at 1:46 p.m., NA-B stated R1 would use her oxygen anytime she was laying down in the bed, she did not like to lie</p>	F 656	<p>meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>R1 no longer resides at the facility.</p> <p>All residents have the potential to be affected by this practice.</p> <p>Each resident's care plans have been reviewed for pertinent diagnosis and ordered interventions along with goals of care.</p> <p>The policy titled Care and Rehab-Ostrander Nursing Policy Formulation of Resident Plan of Care has been reviewed and revised as warranted. Education for the licensed staff completed on 2/21/2025 relating to their roles and responsibilities r/t development of a comprehensive care plan to include pertinent diagnosis and goals of care. All care plans have been reviewed for pertinent diagnosis, ordered interventions as well as the goals of care.</p> <p>Facility will complete audits of 20% of all care plans weekly to assure that the care plans address pertinent diagnosis and ordered interventions.</p> <p>Results of the audits will be presented to QA/QAPI on a quarterly basis to determine continuing auditing frequency.</p> <p>DON and/or designee will responsible</p> <p>Date of Compliance: 02/28/2025</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>OSTRANDER CARE AND REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>305 MINNESOTA STREET</b> <b>OSTRANDER, MN 55961</b>		
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F 656	<p>Continued From page 3 down without it.</p> <p>During an interview on 1/29/25 at 1:53 p.m., director of nursing (DON) stated R1's care plan was not updated to include R1's oxygen use, for obstructive sleep apnea after it was ordered on 4/8/24, and it should have been.</p> <p>During an interview on 1/29/25 at 2:26 p.m., the administrator stated It does not look like R1's care plan was updated to include her oxygen use for obstructive sleep apnea after it was ordered on 4/8/24, and it should have been.</p> <p>Facility policy, "CARE &amp; REHAB-OSTRANDER NURSING POLICY FORMULATION OF RESIDENT PLAN OF CARE," reviewed 7/2022, identified the Policy: Ostrander Care &amp; Rehab will assess and provide guidelines for individualized resident plan of care. Rationale: The facility will establish a plan of care and create goals specified for the resident to reach and maintain the highest level of physical, mental and psychosocial function possible. Procedure: 1. Residents will be assessed upon admission and through nursing assessment the initial care plan will be developed. 2. The comprehensive care plan must be completed within 21 days of admission. 3. Care plans are updated quarterly, unless significant change is warranted. 4. Comprehensive plan of care which includes: resident-specific priority problems, short-term goals and measurable outcomes, interventions to meet the goals, Nursing summary response to interventions, nursing plan changes and recommendations, dietary, rehabilitation, discharge planning and others as applicable. 5. A care plan meeting will be held within 21 days of admission. The IDT will meet with the resident</p>	F 656		

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F 656	Continued From page 4	F 656			
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)  §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F 660		2/21/25	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>OSTRANDER CARE AND REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>305 MINNESOTA STREET</b> <b>OSTRANDER, MN 55961</b>		
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F 660	<p>Continued From page 5</p> <p>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.</p> <p>(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.</p> <p>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.</p> <p>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.</p> <p>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.</p> <p>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's</p>	F 660		

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F 660	<p>Continued From page 6 discharge or transfer. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to provide planning and coordination of services to facilitate a safe discharge to an assisted living facility (ALF) for 1 of 1 residents (R1) reviewed for misappropriation.</p> <p>Findings include:</p> <p>R1's Telephone Order dated 4/8/24, identified to start nocturnal oxygen at 1 liter per nasal canula for obstructive sleep apnea (OSA) and anxiety.</p> <p>R1's care plan dated 5/3/24, identified a focus that R1 required or requested assistance arranging medical appointments. Intervention dated 5/16/24, identified to notify family of appointments, schedule and arrange for transportation to medical appointments. An additional focus revised 9/26/24 identified R1 has agreed to go to an ALF due to inability to return home. R1's county worker was involved with discharge plans as well. Interventions dated 3/27/24 identified to coordinate, facilitate and communicate all plans for follow-up and future care needs and to perform medication reconciliation of all prescribed and non-prescribed medications.</p> <p>R1's care plan did not identify R1's diagnoses of sleep apnea nor did it identify the medical provider ordered intervention to receive oxygen therapy. Further did not identify interventions to assess and monitor for sleep apnea.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 12/2/24, identified R1's cognition to be intact and</p>	F 660	<p>It is the practice of Ostrander Care and Rehab to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care and the reduction of factors leading to preventable readmissions.</p> <p>R1 no longer resides at the facility.</p> <p>Residents preparing for discharge have the potential to be affected by this practice. Care plans have been reviewed to contain the resident/resident's representative goals for discharge along with ordered interventions necessary for a successful discharge.</p> <p>Policy titled Discharge Planning has been reviewed and revised as warranted. Care plans have been reviewed to include discharges goals and plans. Going forward care plans will address discharge plans starting upon admission and updated as necessary with changes in condition or plans. Discharge plans will be reviewed at a minimum of a quarterly basis or with a significant change in condition. DON and/or designees will ensure that all services are arranged and set up prior to discharge. Licensed staff have been educated on the</p>	

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F 660	<p>Continued From page 7</p> <p>diagnoses of OSA (a sleep disorder characterized by repeated episodes of complete or partial blockage of the upper airway during sleep, leading to reduced or absent breathing which can result in low oxygen levels) and congestive heart failure (a chronic condition where the heart muscle weakens and cannot pump blood effectively which can lead to shortness of breath). Further identified oxygen was used.</p> <p>During an interview on 1/29/25 at 11:57 a.m., nursing assistant (NA)-A stated R1 would use her oxygen whenever she would sleep, she thought she used 2 liters at night.</p> <p>During an interview on 1/29/25 at 1:38 p.m., licensed practical nurse (LPN)-A stated R1 used her oxygen while she slept and would get very anxious about sleeping and quite hard to deal with if she didn't have her oxygen.</p> <p>During an interview on 1/29/25 at 1:46 p.m., NA-B stated R1 would use her oxygen anytime she was laying down in the bed, she did not like to lie down without it.</p> <p>R1's discharge summary dated 1/14/25, identified R1 had a planned discharge to the community. The discharge plan did not identify any set up for oxygen services.</p> <p>During a phone interview on 1/29/25 at 3:24 p.m., assisted living registered nurse (ALRN)-A stated on 1/14/25, R1 was admitted to the facility without oxygen services. ALRN-A stated R1 went without oxygen until 1/18/25, when R1 was not feeling well, was dizzy and was having a hard time breathing so the ambulance came and got her, and she was hospitalized until 1/21/25. ALRN-A</p>	F 660	<p>discharging process and their roles and responsibilities on 2/21/2025. Education has been provided to the licensed staff on completing a discharge summary to include a recapitulation of the resident's stay and their roles and responsibilities. The Director of Nursing and/or designee will complete a follow-up call to the resident and/or resident representative, or the receiving location for an appropriate transition of care.</p> <p>Audits will be completed on each discharge for the next 3 months. Results of audits will be reviewed at QA/QAPI quarterly to determine any necessary changes and to determine continued frequency.</p> <p>DON and/or designee will responsible</p> <p>Date of Compliance: 02/28/2025</p>	

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F 660	<p>Continued From page 8</p> <p>stated R1 needs the oxygen at night while she sleeps.</p> <p>R1's Prehospital Care Report dated 1/18/25 at 3:17 p.m., identified an ambulance was dispatched to ALF for R1 who was complaining of difficulty breathing ...facility staff report that R1 was transferred on 1/18/25, from another facility and still had not received R1's oxygen. R1 reported to staff experiencing a near syncopal (fainting) episode 20 minutes prior and still having a hard time breathing.</p> <p>R1's emergency department (ED) Provider note dated 1/18/25, identified R1 presented with a brief episode of lightheadedness and hypoxia ...R1 was supposed to be on home oxygen but has been off it since her recent move. R1 was mildly hypoxic (inadequate supply of oxygen to the body's tissues) in the ED. We are unable to obtain home oxygen tonight and R1 was unable to be admitted to ED observation because of inability to independently safely ambulate. Will admit for further care.</p> <p>R1's hospital admission note dated 1/18/25 identified R1 presented to the ED via EMS due to a near syncopal episode along with feeling weak and lightheaded around 2:30 p.m. and had been on 1L nasal canula (NC) oxygen since 2016 and had moved facilities this past week and has not had been on the oxygen.</p> <p>R1's hospital discharge summary dated 1/18/25 to 1/21/25, identified R1 was supposed to be on oxygen via NC (1 L) at baseline however had not been able to obtain oxygen at her new assisted living facility, had not been using it for the past 4-5 days. R1 was evaluated by respiratory</p>	F 660		

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F 660	<p>Continued From page 9</p> <p>therapy (RT) colleagues for oxygen needs. R1 was found to be saturating above 88% at rest and ambulation, with no need for daytime oxygen. R1 also had nocturnal (night time) oxygen study done that revealed desaturations to 87%, requiring 2 liters/minute nasal canula. Follow up identified a prescription for overnight oxygen of 2 liters/minute nasal canula was sent with R1 for hypoxia due to chronic diastolic heart failure.</p> <p>During a phone interview on 1/29/25 at 10:41 a.m., emergency department social worker (EDSW)-A stated R1 was admitted to the hospital on 1/18/25, due to lightheadedness and hypoxia due to the facility not sending her oxygen to R1's ALF when she discharged and had been without oxygen for 4 days.</p> <p>During a phone interview on 1/29/25 at 11:04 a.m., R1 stated she has used her oxygen at night for years because she stopped breathing in the night. R1 stated when she was discharged from the facility on 1/14/25, to the ALF the facility never sent her oxygen with so she went without it for five nights and the one night she couldn't breathe. R1 stated she ended up in the hospital from not having her oxygen.</p> <p>During a phone interview on 1/29/25 at 9:10 a.m., family member (FM)-B stated R1 discharged from the facility to an ALF on 1/14/25 and her oxygen was not set up ahead of time with northwest respiratory services. FM-B stated R1 needed her oxygen at night for her sleep apnea and when R1 lays down her artificial heart valve doesn't work as well, due to that she had been on oxygen for years. FM-B identified she received a phone call from the hospital on 1/17/25, that R1 had been admitted because she had been without her</p>	F 660		

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F 660	<p>Continued From page 10</p> <p>oxygen for a few days because the prescription did not get written for her oxygen when she left the facility on 1/14/25, to go to the ALF.</p> <p>During an interview on 1/29/25 at 10:18 a.m., medical director (MD)-A stated R1 discharged from the facility on 1/14/25, without a DME order for oxygen. MD-A further stated R1 used the oxygen at night while at the facility for sleep apnea. MD-A indicated without the use of oxygen at night, R1 had the potential for hypoxia and fatigue.</p> <p>During an interview on 1/29/25 at 1:53 p.m., director of nursing (DON) stated R1 did not have R1's oxygen set up for her discharge from the facility on 1/14/25. DON indicated she received a phone call from a nurse at R1's ALF on 1/15/25, asking how to get R1's oxygen. DON indicated she had one of the providers send a prescription for oxygen to Northwest respiratory services (NRS). DON further indicated NRS had wanted her to send over R1's current nocturnal oxygen saturations levels and did not have the data for that so she did not send it as R1 was no longer a resident at their facility. DON indicated she thought R1's county case manager would set up R1's oxygen services and stated since she thought the oxygen was order was sent to NRS she didn't do any more follow up to ensure R1 would receive oxygen services.</p> <p>During an interview on 1/29/25 at 2:31 p.m., the administrator stated they did not have any oxygen orders for R1 sent with for discharge on 1/14/25.</p> <p>During a phone interview on 1/29/25 at 3:56 p.m., with (NRS) intake department trainer (IDT)-A stated R1 discharged from her facility on 1/14/25,</p>	F 660		

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F 660	<p>Continued From page 11</p> <p>and they did not receive an order for R1's oxygen until 1/15/25. IDT-A stated we did not have the information needed to submit to R1's insurance for her nocturnal oxygen use, so we were not able to establish care at R1's new facility. IDT-A stated typically we have a contract with long-term care (LTC) facilities and prior to a residents discharge the facility would contact us to go over necessary information needed for insurance verification to see if this is a service we can provide outside of the contracted nursing facility. On 1/16/25, we asked the facility for nocturnal oxygen saturations for R1, and we never received them. IDT-A stated we needed recent documentation that supports the continued need for oxygen in a home setting for insurance purposes. IDT-A stated we finally got everything we needed from the nurse at the ALF on 1/24/25, and R1's oxygen was then set up.</p> <p>Facility Policy, "DISCHARGE PLANNING POLICY," revised 8/2018, identified a purpose that the interdisciplinary team shall prepare a comprehensive discharge care plan with the resident and resident representative to assist the resident to reach their discharge goal ...4. Discharge a. If the resident is being discharged to a lower level of care within the facility, the facility will document the discharge plan and approaches as developed via the comprehensive care planning process (See Discharge Transfer Policy). b. If the resident desires returning to the community, document any referrals to Local Contact Agencies or other appropriate entities for the purpose of discharge (if applicable). c. Update the resident's comprehensive care plan and discharge plan (if applicable) with any information received form referrals to local contact agencies or other appropriate entities ...7.</p>	F 660		

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F 660	Continued From page 12 Information for the Receiving Provider: The facility will share relevant information with the post-discharge care provider, including a. The resident's primary care physician and other consulting practitioners as well as their respective and contact information. a. The resident representative's contact information b. The resident's Advance Directives, c. All special instructions or precautions and for ongoing care as appropriate, d. The resident's comprehensive care plan goals, e. A copy of the discharge summary, and f. Any other necessary or relevant information or documentations to facilitate safe and effective transition of care. 8. Discharge Summary: a. A discharge summary will be completed upon discharge to include: a recapitulation of the residents stay in the facility (diagnoses, course of illness/treatment, therapy, lab, radiology and consultation reports, a final summary of resident status, medication reconciliation, a post-discharge plan of care developed with the resident and resident representative: Location/Agency/Facility where resident will reside, arrangements for care, medications and services post-discharge, arrangements for follow up communication post-discharge. 9. Discharge Follow Up Process: a. Upon discharge (internally or externally), social services or designee will complete follow up calls or visits with the resident, resident representative and receiving location (insert facility and state specific information here) for an appropriate transition of care, b. If areas of additional care coordination are needed, the facility representative and applicable team members will assist in the care coordination process. (insert transition of care policy information here) and c. documentation of discharge follow up will be completed per policy. (insert transition of care	F 660		

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F 660	Continued From page 13 policy information here).	F 660			

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 1/28/25 and 1/29/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>02/21/25</b>
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2 000	<p>Continued From page 1</p> <p>and identify the date when they will be completed.</p> <p>The following complaint was reviewed: H54645760C (MN110024) with a licensing order issued at 0565.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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 &lt;<a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a>&gt; The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of</p>	2 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00922</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OSTRANDER CARE AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>305 MINNESOTA STREET OSTRANDER, MN 55961</b>
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2 000	Continued From page 2  state form.  PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	<p>MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use</p> <p>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure comprehensive care plans were developed to implement care and services for oxygen therapy due to obstructive sleep apnea (OSA), for 1 of 1 residents (R1) reviewed for discharge.</p> <p>Findings include:</p> <p>R1's Telephone Order dated 4/8/24, identified to start nocturnal oxygen at 1 liter per nasal canula for OSA and anxiety.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 12/2/24, identified R1's cognition to be intact and diagnoses of obstructive sleep apnea (a sleep disorder characterized by repeated episodes of complete or partial blockage of the upper airway during sleep, leading to reduced or absent</p>	2 565	<p>It is the practice of Ostrander Care and Rehab to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. R1 no longer resides at the facility.</p> <p>All residents have the potential to be affected by this practice. Each resident's care plans have been reviewed for pertinent diagnosis and ordered interventions along with goals of care.</p> <p>The policy titled Care and Rehab-Ostrander Nursing Policy</p>	2/21/25

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2 565	<p>Continued From page 3</p> <p>breathing which can result in low oxygen levels). Further identified R1 used oxygen while a resident.</p> <p>R1's care plan was reviewed and did not identify R1's diagnoses of sleep apnea nor did it identify the medical provider ordered intervention to receive oxygen therapy. Further did not identify interventions to to manage/treat the disorder with goals of care.</p> <p>During an interview on 1/29/25 at 11:57 a.m., nursing assistant (NA)-A stated R1 would use her oxygen whenever she would sleep, she thought she used 2 liters at night.</p> <p>During an interview on 1/29/25 at 1:38 p.m., licensed practical nurse (LPN)-A stated R1 used her oxygen while she slept, R1 would get very anxious about sleeping, and quite hard to deal with if she didn't have her oxygen.</p> <p>During an interview on 1/29/25 at 1:46 p.m., NA-B stated R1 would use her oxygen anytime she was laying down in the bed, she did not like to lie down without it.</p> <p>During an interview on 1/29/25 at 1:53 p.m., director of nursing (DON) stated R1's care plan was not updated to include R1's oxygen use, for obstructive sleep apnea after it was ordered on 4/8/24, and it should have been.</p> <p>During an interview on 1/29/25 at 2:26 p.m., the administrator stated It does not look like R1's care plan was updated to include her oxygen use for obstructive sleep apnea after it was ordered on 4/8/24, and it should have been.</p> <p>Facility policy, "CARE &amp; REHAB-OSTRANDER</p>	2 565	<p>Formulation of Resident Plan of Care has been reviewed and revised as warranted. Education for the licensed staff completed on 2/21/2025 relating to their roles and responsibilities r/t development of a comprehensive care plan to include pertinent diagnosis and goals of care. All care plans have been reviewed for pertinent diagnosis, ordered interventions as well as the goals of care.</p> <p>Facility will complete audits of 20% of all care plans weekly to assure that the care plans address pertinent diagnosis and ordered interventions. Results of the audits will be presented to QA/QAPI on a quarterly basis to determine continuing auditing frequency.</p> <p>DON and/or designee will responsible</p> <p>Date of Compliance: 02/28/2025</p>	
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2 565	<p>Continued From page 4</p> <p>NURSING POLICY FORMULATION OF RESIDENT PLAN OF CARE," reviewed 7/2022, identified the Policy: Ostrander Care &amp; Rehab will assess and provide guidelines for individualized resident plan of care. Rationale: The facility will establish a plan of care and create goals specified for the resident to reach and maintain the highest level of physical, mental and psychosocial function possible. Procedure: 1. Residents will be assessed upon admission and through nursing assessment the initial care plan will be developed. 2. The comprehensive care plan must be completed within 21 days of admission. 3. Care plans are updated quarterly, unless significant change is warranted. 4. Comprehensive plan of care which includes: resident-specific priority problems, short-term goals and measurable outcomes, interventions to meet the goals, Nursing summary response to interventions, nursing plan changes and recommendations, dietary, rehabilitation, discharge planning and others as applicable. 5. A care plan meeting will be held within 21 days of admission. The IDT will meet with the resident and/or advocate to discuss the formal determination of the residents plan of care as indicated by the MDS.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine</p>	2 565		
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2 565	<p>Continued From page 5</p> <p>compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 565		