STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245464	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ostrander Care and Rehab	305 Minnesota Street Ostrander, MN 55961

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 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. Findings include: R1's Telephone Order dated 4/8/24, identified to start nocturnal oxygen at 1 liter per nasal canula for OSA and anxiety. R1's quarterly Minimum Data Set (MDS) dated [DATE], 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. 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. 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. 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. 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. 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. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245464	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Facility policy, CARE & REHAB-[NAME] NURSING POLICY FORMULATION OF RESIDENT PLAN OF CARE, reviewed 7/2022, identified the Policy: [NAME] Care & 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 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. Findings include: 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. 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. 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. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1's cognition to be intact and 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. 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. 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. 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. 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. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 stated R1 needs the oxygen at night while she sleeps. 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. 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. 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. 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 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. 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. 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. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 oxygen for a few days because the prescription did not get written for her oxygen when she left the faciity on [DATE], to go to the ALF. 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. . 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. 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. 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, 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. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 policy information here).