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	04/15/2026

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Notice of Medicare Non-Coverage (NOMNC CMS-10123) and the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN CMS10055) were provided to 1 of 3 residents (R30) reviewed for beneficiary notification.Findings Include: R30 was admitted on [DATE], Medicare part A identified as primary payer, Medicare part A skilled services ended on12/19/2025, and private pay started on 12/20/2025. Record review indicated R30's son as care and financial power of attorney (POA). R30's last day of Medicare part A skilled services was on12/19/2025. The Notice of Medicare Non-Coverage (NOMNC CMS-10123) provided by facility for review was not signed or dated by the resident or representative. An undated nor signed handwritten note on page 2, under the Additional Information title stated spoke with family member (FM)-A, sister. Family does not want to appeal. The facility director of nursing, (DON) confirmed, the unsigned and undated handwritten note was hers. Based on a phone interview on 04/15/2026 9:26 a.m., FM-A stated had visited more often than other family members but was not POA. FM -A did not recall any specific conversation with the facility DON in reference to the possibility of appeal and stated, we were just told therapy was going to stop. Facility was unable to provide a signed copy of the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) for review. During an interview with on 04/15/2026 10:08 a.m., DON stated, had not presented R30's family a copy of the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) for review and signature. A facility policy titled [NAME] care and Rehab Administration policy Rates and Charges/Medicare Policy reviewed on 2/2025 states,1. OCR must inform the resident or the resident agent/guardian before any changes in charges for services not covered under Medicare or Medicaid or by nursing home per diem rate. 5. Residents admitted under Medicare A will be informed within 48 hours of the need for denial of benefits pending change. 7. The Medicare denial will be explained to the resident or their responsible person and the reason of denial prior to obtaining the signature on the form.

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