DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 29, 2022

CMS Certification Number (CCN): 245550

Administrator
North Star Manor
410 South McKinley Street
Warren, MN 56762

Dear Administrator:

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 July 15, 2022 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 29, 2022

Administrator
North Star Manor
410 South McKinley Street
Warren, MN 56762

RE: CCN: 245550
Cycle Start Date: May 25, 2022

Dear Administrator:

On July 27, 2022, we notified you a remedy was imposed. On July 22, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 15, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 25, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 17, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 25, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 15, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
June 17, 2022

Administrator
North Star Manor
410 South McKinley Street
Warren, MN 56762

RE: CCN: 245550
Cycle Start Date: May 25, 2022

Dear Administrator:

On May 25, 2022, a 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 August 25, 2022 (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 November 25, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	C 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH STAR MANOR	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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
E 000	Initial Comments On 5/22/22 through 5/25/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/22/22 through 5/25/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The complaint H55501753C (MN83414) was found to be unsubstantiated. 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 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		7/8/22

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

Electronically Signed | 06/24/2022

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 686 SS=D	Continued From page 1 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure timely repositioning to promote healing and prevent further pressure ulcer development for 1 of 1 residents (R25) reviewed for pressure ulcers. Findings include: R25's quarterly minimum data set (MDS) dated 4/22/22, identified R25 had severe cognitive impairment and required assist of two staff for turning and repositioning. R25 was at risk for pressure ulcers and used a pressure reducing mattress, a pressure reducing wheelchair cushion, and was on a turning/repositioning program. R25's Tissue Tolerance - V4 assessment dated 4/22/22, identified R25 had a dark red blanchable area of skin on the coccyx/buttocks and was scheduled to be turned/repositioned every two	F 686	F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. How corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice: • One on one coaching completed with the CNA identified that did not follow resident's care plan. Followed NSM disciplinary policy. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: • Any resident on a turning and repositioning schedule has the potential to be affected by the same alleged deficient practice. • Review each resident care plans to identify who is currently on a turning and repositioning schedule.	

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F 686	Continued From page 2 hours. R25's care plan dated 5/25/22, identified R25 was unable to independently sit up in bed, move extremities, ambulate or participate in any activities of daily living (ADL's). R25 was at risk for pressure ulcers due to a cerebral vascular accident. The care plan directed staff to turn, reposition and apply barrier cream to R25's bottom every two hours and as needed. Continuous observation was conducted on 5/24/22, at 7:17 a.m. through 10:31 a.m. R25 was lying flat on his back. The head of the bed was elevated at approximately 25-30 degrees. R25 remained in the same position and no staff entered R25's room for a total of 2 hours and 53 minutes. During interview on 5/24/22, at 10:31 a.m. registered nurse (RN)-B stated staff repositioned R25 the morning of 5/24/22, around 6:40 a.m. and was not aware of if R25 was repositioned since 6:40 a.m. RN-B stated R25 should be repositioned every 2 hours. -At 10:35 a.m. R25 was repositioned by RN-B. During interview on 5/24/22, at 2:15 p.m. nursing assistant (NA)-A and NA-B stated they assisted R25 with repositioning the morning of 5/24/22, at approximately 6:30 a.m. and then again after lunch at approximately 12:45 p.m. NA-A and NA-B stated they had not repositioned R25 between 6:30 a.m. and 12:45 p.m. NA-A and NA-B stated R25 was supposed to be repositioned every 2 hours and as needed. - At 2:44 p.m. RN-A stated R25 should be	F 686	3. Measures put into place/changes made to ensure the alleged deficient practice will not recur: • Education to all nursing staff regarding the Repositioning policy • Education to all nursing staff regarding repositioning to prevent pressure ulcers - Educare module assigned to all nursing staff. • Provided timers to nursing staff to utilize for additional options for maintaining proper turning schedule • Reviewing and updated policies • Ensuring that turning and repositioning shows up as a task in POC to ensure it is completed and documented. 4. How the facility will monitor its corrective actions to ensure the alleged deficient practice is being corrected and will not recur: • Audits will be completed on 50% of randomly selected residents who are on a turning and repositioning schedule. Audits will be conducted two times per week for four weeks, then one time a week for four weeks, then every other week for eight weeks, then ongoing as needed by DON or designee. • Audit will be conducted in accordance with MDS schedule, by DON or designee, on each resident to ensure that turning and repositioning when indicated shows up as a task in POC.	

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F 686	Continued From page 3 repositioned every 2 hours as the care plan directs. RN-A stated R25 was at high risk for pressure ulcers and was not appropriate to wait nearly 3 hours to be repositioned. The facilities Repositioning policy revised 7/20/21, identified repositioning as an effective intervention for preventing skin breakdown, promoting circulation, providing pressure relief and was critical for an immobile or dependent resident. The policy further identified staff were to comprehensively assess the resident, develop a plan of care, document the plan on the resident's care plan, monitor/re-evaluate and report any changes to the supervisor.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain respiratory equipment per manufacturer's recommentation for 1 of 1 resident (R24) who required a bilevel positive airway pressure (BiPAP- a type of ventilator that is used to treat sleep apnea) Finding include,	F 695	F695 – Respiratory/Tracheostomy Care and Suctioning How corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice: The cleaning procedure was added to	7/8/22

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F 695	Continued From page 4 R24's significant change Minimum Data Set (MDS) dated 5/8/22, identified R24 had no cognitive impairment. R24's diagnosis included obstructive sleep apnea and identified R24 required respiratory therapy to include use of BiPAP. R24's Respiratory Assessment dated 5/2/22, identified R24 used the BiPAP daily. The nurse's aide care sheet dated 5/23/22, R24 had a BiPAP, and they were to check care plan for instruction or frequency for cleaning of the BiPAP. R24's care plan 5/25/22, lacked instruction or frequency for cleaning of the BiPAP. R24's medical record lack lacked instruction or frequency for cleaning of the BiPAP. During an interview on 5/22/22, at 2:57 p.m. R24 stated she wore the BiPAP every night and was unsure if the staff have ever cleaned it. R24 was observed on 5/24/22, at 9:03 a.m. and on 5/25/22, at 9:31 a.m. in bed with the BiPAP on and running. During an interview on 5/25/22, at 9:33 a.m. nursing assistant (NA)-C stated she had not cleaned R24's BiPAP and did not know how often it would need to be cleaned. During an interview on 5/25/22, at 9:37 a.m. licensed practical nurse (LPN)-A stated she believed the BiPAP was on a schedule for cleaning once a week and would be completed and documented by the NA's.	F 695	the resident care plan and POC. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents have a respiratory assessment completed on admission and quarterly. Any resident noted to be on a Bi-pap or C-pap could be affected by the same alleged deficient practice. An audit was conducted of all current residents, one additional resident was noted to have the same type of respiratory device. A review was completed of the Residents medical record including care plan and POC documentation. This resident was found to be in compliance. Provide education to nursing staff on policies and procedures involving CPAP and BIPAP equipment. Measures put into place/changes made to ensure the alleged deficient practice will not recur: Nurse completing MDS will review the respiratory assessment and verify that any resident with a Bi-pap or C-pap will correctly be added to care plan/POC. Provided education to RN charge regarding adding into care plan.	

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F 695	Continued From page 5 During an interview on 5/25/22, at 9:55 a.m. NA-D stated she thought the BiPAP was cleaned monthly but was unsure. Instructions for cleaning would be on the NA point of care assignments (aide care sheet). She stated she had cleaned it once after resident was first admitted. During an interview on 5/25/22, at 10:31 a.m. NA-F she had not cleaned R24's BiPAP and was unaware of how often it would need to be cleaned. During an interview on 5/25/22, at 10:36 a.m. LPN-A came back and clarified the BiPAP's were to be cleaned daily by the NA's on the evening shift and would be documented in point of care documentation. During an interview on 5/25/22, at 10:54 a.m. NA-G stated BiPAP's were to be cleaned daily on the evening shift and charted in the point of care. During an interview on 5/25/22, at 2:15 p.m. the director of nursing (DON) stated the regular procedure for residents who come in with a CPAP or a BiPAP was to be cleaned daily and placed on the point of care charting and it would be the NA's responsibility. There were no instructions or frequency for cleaning R24's BiPAP and would have expected it to be in the point of care. She was unsure if the BiPAP had been cleaned because there was no documentation. The manufacturer's instructions for the BiPAP identified mask and tubing was to be cleaned at a minimum of twice a week, or to follow facility policy.	F 695	Within the admit screener respiratory assessment, a box is available for nursing to check when care planning is completed. This is a reminder (in the assessment) for the nurse to add this to care plan, which then will be added into POC for charting and notification purposes automatically. Ensuring that respiratory equipment cleaning shows up as a task in POC to ensure it is completed and documented. The DON or designee will review PCC documentation daily to identify any new orders involving respiratory care. Reviewed current policy with all nursing staff. How the facility will monitor its corrective actions to ensure the alleged deficient practice is being corrected and will not recur: Audits will be completed on all admissions regarding use of Bi-pap or C-pap for the next 4 months then ongoing as needed by the DON or designee. Audit will be conducted in accordance with MDS schedule, by DON or designee, on each resident to ensure that respirator equipment cleaning shows up as a task in POC.	

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F 695	Continued From page 6 The facility's CPAP/BiPAP Support policy dated 2/10/21, identified BiPAP masks, nasal pillows, short tubing, and humidifiers are to be cleaned daily by placing in warm soapy water and soaking/agitating for 3-5 minutes. Would need to rinse with warm water and let air dry. The rest of the equipment for the BiPAP was to be cleaned weekly.	F 695	The DON or designee will randomly audit 100 % of residents with respiratory devices weekly for the next 4 months then ongoing as needed to ensure cleaning is conducted per policy as assigned.	

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	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2022**

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NORTH STAR MANOR	**410 SOUTH MCKINLEY STREET** **WARREN, MN 56762**

(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 FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/24/2022. At the time of this survey, North Star Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/24/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Facility was inspected as 1 building with the code change as of November 1, 2016 North Star Manor was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2022**

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K 000	Continued From page 2 and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier. The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 The facility has a capacity of 45 beds and had a census of 37 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and	K 223		6/24/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2022**

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K 223	Continued From page 3 * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/24/2022 between 9:00am and 1:00pm, it was revealed by observation that patient rooms 609 and 610 had been converted to storage room. The doors to these rooms did not have self-closing devices. An interview with Maintenance Manager and facility Administrator verified this deficient finding at the time of discovery.	K 223	K223 – Doors with Self-Closing Devices 1. Corrective action taken or planned to correct the deficiency: • All unoccupied resident rooms have been emptied of all stored items and restored to resident rooms. Since rooms are no longer being utilized for storage, no automatic closure is required. 2. Measures that will be put in place to ensure the deficiency does not reoccur: • Education provided to staff regarding not utilizing unoccupied resident rooms for storage 3. How the facility plans to monitor future performance to ensure solutions are sustained: • Plant Director or designee will monitor unoccupied resident rooms on a weekly basis to ensure rooms are not being used for storage. 4. Who is responsible for the corrective actions and monitoring of compliance: • Plant Director will be responsible for ensuring corrective actions are sustained and monitoring compliance.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245550	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**5/24/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 351	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/24/2022 between 9:00am and 1:00pm, it was revealed by observation that supplies were stored within 18 inches of sprinkler system in storage room located off main dining room. The storage was corrected before the exit of the survey. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.

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The above isolated deficiencies pose no actual harm to the residents