

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C4RT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00627

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245330
2. STATE VENDOR OR MEDICAID NO. (L2) 943188800
3. NAME AND ADDRESS OF FACILITY (L3) COUNTRY MANOR HEALTH & REHAB CTR
4. TYPE OF ACTION: 7 (L8)
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY 03/28/2016 (L34)
7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
8. ACCREDITATION STATUS: (L10)
9. LTC PERIOD OF CERTIFICATION
10. THE FACILITY IS CERTIFIED AS: X A. In Compliance With
11. Total Facility Beds 165 (L18)
12. Total Certified Beds 165 (L17)
13. LTC CERTIFIED BED BREAKDOWN
14. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)
15. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
17. SURVEYOR SIGNATURE Austin Fry, HFE NE II Date: 03/28/2016 (L19)
18. STATE SURVEY AGENCY APPROVAL Kate JohnsTon, Program Specialist Date: 04/08/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Participate
20. COMPLIANCE WITH CIVIL RIGHTS ACT:
21. 1. Statement of Financial Solvency (HCFA-2572)
22. ORIGINAL DATE OF PARTICIPATION 07/01/1986 (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)
26. TERMINATION ACTION: 00 (L30)
27. ALTERNATIVE SANCTIONS
28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. 03001 (L31)
30. REMARKS
31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE 04/05/2016 (L33)
DETERMINATION APPROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245330
April 8, 2016

Mr. Brian Kelm, Administrator
Country Manor Health & Rehab Center
520 First Street Northeast
Sartell, Minnesota 56377

Dear Mr. Kelm:

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 March 25, 2016 the above facility is certified for or recommended for:

165 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 165 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Country Manor Health & Rehab Ctr

April 8, 2016

Page 2

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 8, 2016

Mr. Brian Kelm, Administrator
Country Manor Health & Rehab Center
520 First Street Northeast
Sartell, Minnesota 56377

RE: Project Number S5330026

Dear Mr. Kelm:

On March 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 24, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 1, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 24, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 24, 2016, effective March 25, 2016 and therefore remedies outlined in our letter to you dated March 1, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Country Manor Health & Rehab Ctr

April 8, 2016

Page 2

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245330	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 3/28/2016	Y3
NAME OF FACILITY COUNTRY MANOR HEALTH & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0154	Correction	ID Prefix F0356	Correction	ID Prefix	Correction
Reg. # 483.10(b)(3), 483.10(d) (2)	Completed	Reg. # 483.30(e)	Completed	Reg. #	Completed
LSC	03/25/2016	LSC	03/25/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) JS/KJ	DATE 04/08/2016	SIGNATURE OF SURVEYOR 33925	DATE 03/28/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/24/2016

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245330	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING B. Wing	Y2	DATE OF REVISIT 4/1/2016	Y3
NAME OF FACILITY COUNTRY MANOR HEALTH & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # NFPA 101 LSC K0056	Correction Completed 03/18/2016	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed _____

REVIEWED BY STATE AGENCY	<input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) TL/KJ	DATE 04/08/2016	SIGNATURE OF SURVEYOR 27200	DATE 04/01/2016
REVIEWED BY CMS RO	<input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/22/2016	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

April 8, 2016

Mr. Brian Kelm, Administrator
Country Manor Health & Rehab Center
520 First Street Northeast
Sartell, Minnesota 56377

Re: Enclosed Reinspection Results - Project Number S5330026

Dear Mr. Kelm:

On March 28, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 24, 2016, with orders received by you on March 4, 2016. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 00627	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 3/28/2016
NAME OF FACILITY COUNTRY MANOR HEALTH & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21426	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	03/25/2016	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) JS/KJ	DATE 04/08/2016	SIGNATURE OF SURVEYOR 33925	DATE 03/28/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/24/2016

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C4RT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00627

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245330	3. NAME AND ADDRESS OF FACILITY (L3) COUNTRY MANOR HEALTH & REHAB CTR (L4) 520 FIRST STREET NORTHEAST (L5) SARTELL, MN (L6) 56377	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
2. STATE VENDOR OR MEDICAID NO. (L2) 943188800		FISCAL YEAR ENDING DATE: (L35) 06/30
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE	
6. DATE OF SURVEY 02/24/2016 (L34)	10. THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements _____ 2. Technical Personnel _____ 6. Scope of Services Limit Compliance Based On: _____ 3. 24 Hour RN _____ 7. Medical Director _____ 1. Acceptable POC _____ 4. 7-Day RN (Rural SNF) _____ 8. Patient Room Size _____ 5. Life Safety Code _____ 9. Beds/Room	
8. ACCREDITATION STATUS: _____ (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		
12. Total Facility Beds 165 (L18)		
13. Total Certified Beds 165 (L17)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 165 (L37) (L38) (L39) (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE <u>Annette Trueebenbach, HFE NE II</u> (L19)	Date : <u>03/16/2016</u>	18. STATE SURVEY AGENCY APPROVAL <u>Kate JohnsTon, Program Specialist</u> (L20)
Date: <u>04/05/2016</u>		

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY ____ 1. Facility is Eligible to Participate ____ 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____
22. ORIGINAL DATE OF PARTICIPATION 07/01/1986 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)	26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO. 03001 (L28)	30. REMARKS Posted 04/05/2016 Co. DETERMINATION APPROVAL
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2762

March 1, 2016

Mr. Brian Kelm, Administrator
Country Manor Health & Rehabilitation Center
520 First Street Northeast
Sartell, Minnesota 56377

RE: Project Number S5330026

Dear Mr. Kelm:

On February 24, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 24, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5330022 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 10, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected

by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by May 24, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 24, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

**Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900**

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

**Mr. Tom Linhoff, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145**

Country Manor Health & Rehab Ctr

March 1, 2016

Page 6

Email: tom.linhoff@state.mn.us

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245330	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2016
NAME OF PROVIDER OR SUPPLIER COUNTRY MANOR HEALTH & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377		
(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 The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was also completed at the time of the standard survey, complaint H5330022, and was unsubstantiated.	F 000			
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure laboratory results were provided to 1 of 1 residents (R102) who expressed he was not notified of them on a consistent and timely basis.	F 154	Plan of Correction 1. The facility will review all lab results when received with Resident R102. 2. Facility policy will be updated to denote licensed nursing staff are responsible for keeping residents updated on health status; including lab results. 3. Licensed nursing staff will review the updated policy and sign to acknowledge their understanding of expectations.	OK 3/16/16 JL	

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

[Signature]

TITLE

CEO/Adm

(X6) DATE

3-11-2016

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

RECEIVED

MAR 16 2016

MN Dept of Health
Fergus Falls

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

PRINTED: 03/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245330	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2016
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F 154	Continued From page 2 something was abnormal, non-routine, or, "If the patient asks about them," but otherwise the nursing staff did not routinely notify residents of their laboratory results. When interviewed on 2/24/16, at 11:03 a.m. the assistant director of nursing (ADON) stated the nursing staff or physician were responsible to make sure residents were notified of their laboratory results. A facility Laboratory Services policy dated 12/2015, identified laboratory tests were used, "For purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings." Further, the policy identified staff would update the resident or family with abnormal results, however did not identify who or how residents would be notified of non-abnormal results to ensure they were informed of their health status.	F 154			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	Plan of Correction F356 1. The facility will post the following: facility name, current date, resident census, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift; Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 246330	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2016
NAME OF PROVIDER OR SUPPLIER COUNTRY MANOR HEALTH & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377		
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F 356	<p>Continued From page 4</p> <p>When interviewed on 2/21/16, at 11:36 a.m. receptionist (RCP)-A stated the postings listed were not current, and she was not sure why. "[I'm] not entirely sure why they're from a week ago."</p> <p>During interview on 2/21/16, at 5:40 p.m. the director of nursing (DON) stated the postings displayed by the main entrance were the only area of the building the hours are posted for the public and residents to view, and the registered nurse (RN) supervisors were responsible to change them on the weekends. The DON reviewed the incorrect postings and stated the dates were inaccurate, and the facility census should have been identified on the postings.</p> <p>A facility Nursing Hours policy dated 4/2015, identified the posting was used to, "Communicate with residents and family that the [facility] has sufficient staff to meet the resident's needs." The policy identified a procedure which included to post the hours on a daily basis and include the resident census.</p>	F 356			

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

F5330024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245330	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER COUNTRY MANOR HEALTH & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 620 FIRST STREET NORTHEAST SARTELL, MN 56377	
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>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.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Country Manor Health & Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145</p>		<p>APPROVED <i>Tom Linhoff</i></p> <p>By Tom Linhoff at 2:55 pm, Mar 15, 2016</p>	



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

Dean C. P...

TITLE

CEO/...

(X6) DATE

3-11-2016

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

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K 000	<p>Continued From page 1 ST. PAUL, MN 55101-5145, or</p> <p>By e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. <p>The facility was inspected as two separate buildings:</p> <p>Country Manor Health & Retirement is a 1 story building with no basement and is fully sprinklered. The building was constructed at 8 different times. The original building was constructed in 1970 and was determined to be of Type II(000) construction. In 1975, the 300 Wing was added to the south that was determined to be of Type II(000) construction. In 1979 the 100 Wing was added to the north that was determined to be of Type V(111) construction. In 1981 additions were added to the west and east of the 100 Wing which were determined to be Type V(111) construction. In 1984 the Chapel was added to the southeast of 300 Wing that was determined to be of Type V(111) construction. In 1996 an</p>	K 000		

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K 000	Continued From page 2 addition was added to the Kitchen that was determined to be of Type V(111) construction. In 2001 an addition was added to the Main Entrance/Cafe that was determined to be of Type V(111) construction. In 2011 a two story addition was added and was determined to be of Type II(111) construction. Because the original building and the additions do not meet the construction types allowed for existing buildings, the facility was surveyed as two buildings. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 165 beds and had a census of 159 at the time of the survey. The requirement at 42 CFR, Subpart 485.623 (d) is NOT MET.	K 000	Plan of Correction K056 1. Identified corroded fire sprinkler heads located in the dishwashing room will be replaced by Simplex Grinnell. 2. A preventative maintenance work order was implemented and will be reviewed monthly. 3. Brett Avery, Director of Maintenance, will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler	K 056	Date of Completion: 3/18/16		

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K 056	<p>Continued From page 3</p> <p>system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect all residents, visitors and staff of the facility.</p> <p>Findings include:</p> <p>On facility tour between 10:30 AM to 1:30 PM on 02/22/2016, observations revealed that there are corroded fire sprinkler heads located in the dish washing room of the kitchen.</p> <p>This deficient practice was verified by the Maintenance Supervisor (BS).</p>	K 056			

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

F5330024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245330	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2011 TWO STORY ADDITION B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2016
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NAME OF PROVIDER OR SUPPLIER COUNTRY MANOR HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Country Manor Health Care and Rehab Center's Two Story Addition was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Car</p> <p>Country Manor Health Care and Rehab Center's building 2 is a 2-story addition with no basement. The addition was constructed in 2011 and was determined to be Type II (111). The addition is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 165 beds and had a census of 154 at the time of the survey.</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is MET.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO/Adm	(X6) DATE 3-11-2016
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7011 0470 0000 5262 2762

March 1, 2016

Mr. Brian Kelm, Administrator
Country Manor Health & Rehabilitation Center
520 First Street Northeast
Sartell, Minnesota 56377

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5330026

Dear Mr. Kelm:

The above facility was surveyed on February 21, 2016 through February 24, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5330022 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division #212, St Cloud MN, 56301. 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 me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00627	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2016
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NAME OF PROVIDER OR SUPPLIER COUNTRY MANOR HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</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 February 21st, 22nd, 23rd, and 24th, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of</p>	2 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00627	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2016
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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000		
21426	<p>MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control</p> <p>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) Written compliance with this subdivision must be maintained by the nursing home.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure the millimeters of induration for the tuberculin skin test (TST) were documented for 1 of 5 residents (R369) and failed to document the TST result identifying if it was negative or positive for 4 of 5 residents (R369, R310, R201, and R37). This had the potential to</p>	21426		

Minnesota Department of Health

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21426	<p>Continued From page 2</p> <p>affect all 159 residents.</p> <p>Findings include:</p> <p>R369 was admitted to the facility on 2/1/16, according to an entry tracking record Minimum Data Set (MDS) dated 2/1/16.</p> <p>A Clinical Record of Immunizations indicated R369 had a first step TST on 2/1/16, with a result of negative, however, the millimeters (mm) of induration was not documented. R369 had a second step TST on 2/15/16, with a result of no mm of induration, with no reading of positive or negative.</p> <p>R310 was admitted to the facility on 1/24/16, according to the admission MDS dated 1/30/16.</p> <p>A Clinical Record of Immunizations indicated R310 had a first step TST on 1/24/16, and the second step on 2/9/16, both had results read as no mm of induration, however, neither identified if the results were positive or negative.</p> <p>R201 was admitted to the facility on 1/28/16, according to the admission MDS dated 2/4/16.</p> <p>A Clinical Record of Immunizations indicated R201 had a first step TST on 1/28/16, and the second step TST on 2/12/16, both had results read as no mm of induration, however, neither identified if the results were positive or negative.</p> <p>R67 was admitted to the facility on 1/25/16, according to the admission MDS dated 1/31/16.</p> <p>A Clinical Record of Immunizations indicated R67 had a first step TST on 1/25/16, and a second step TST on 2/8/16, both had results read as no</p>	21426		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00627	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2016
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NAME OF PROVIDER OR SUPPLIER COUNTRY MANOR HEALTH & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377
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21426	<p>Continued From page 3</p> <p>mm of induration, however, neither identified if the results were positive or negative.</p> <p>During an interview on 2/24/16, at 10:48 a.m. registered nurse (RN)-A stated staff would be educated on TST documentation to ensure they are documenting the results of negative or positive, and the mm of induration.</p> <p>A facility policy TB [tuberculosis] Control Program Overview dated 12/15, lacked direction on how to document and interpret the results of a TST for residents.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the facility system in place to ensure residents TST readings are documented as required by state rule. The administrator or designee could educate staff on the system in place, and monitor TST results documented.</p> <p>TIME PERIOD FOR CORRECTION: Twenty one (21) days.</p>	21426		