Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 17, 2025

Administrator
Country Manor Health & Rehab Ctr
520 First Street Northeast
Sartell, MN 56377

RE: CCN: 245330
Cycle Start Date: January 23, 2025

Dear Administrator:

On March 10, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 5, 2025

Administrator
Country Manor Health & Rehab Ctr
520 First Street Northeast
Sartell, MN 56377

RE: CCN: 245330
Cycle Start Date: January 23, 2025

Dear Administrator:

On January 23, 2025, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 23, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 23, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245330	A. BUILDING _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR HEALTH & REHAB CTR	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
E 000	Initial Comments On 1/21/25 through 1/23/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 1/21/25 through 1/23/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53305001C (MN106966). 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 substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/12/2025

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

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor 1 of 2 residents (R97) reviewed for wound care. Findings include: R97's quarterly Minimum Data Set (MDS) dated 12/8/24, included R97 had moderate cognitive impairment. R97 had a diagnosis of dementia. R97's encounter summary dated 12/20/24 from Central MN Foot & Ankle included "Staff at Country Manor are to clean the right great toe with warm water and gentle soap; gently pat dry, then apply a thin layer of triple antibiotic ointments followed by a band-aid until healed." R97's interdisciplinary notes dated 12/20/24, included "right great toe bandage changed. Mild bleeding noted. Cleaned and applied abx ointments." Interdisciplinary notes failed to include additional entries describing skin impairment or treatment. During interview on 1/22/25 at 4:56 p.m., registered nurse (RN)-A stated she was unsure if	F 684	F684 1. Corrective action for resident identified in deficiency: - R97 returned from routine podiatry appointment on 12/20/2024; podiatry dictation denoted and reflected an evulsion of R great toenail. Prescribed treatment was added to ETAR to treat right great toe once daily with warm water, gentle soap and gently pat dry. Apply thin layer of antibiotic ointment with band aid until healed. It was identified that daily treatment was completed to right great toe per documentation in ETAR and validated by staff interviews. Upon review of documentation, it was noted that interdisciplinary notes failed to include additional entries describing skin impairment and treatment. On 1/22/2025 to present,licensed nursing staff included in the interdisciplinary notes a description of skin impairment and prescribed treatment. 2. The facility will identify other residents	3/4/25

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F 684	Continued From page 2 R97 had a skin impairment to her right great toe. RN-A confirmed R97's electronic medical record (EMR) lacked monitoring and documentation on a skin impairment to the right great toe. RN-A confirmed there was a daily wound care order for R97 which was being documented on daily as being completed. During interview on 1/23/25 at 9:34 a.m., director of nursing (DON) stated there should be monitoring set up when a resident has a skin impairment. The DON stated wound documentation including appearance, size and drainage should have been completed at a minimum weekly. The DON confirmed there was an order for daily wound care to R97's right great toe. The DON confirmed R97's EMR failed to include any documentation of a skin impairment to R97's right great toe since 12/20/24. The DON stated it was important to have monitoring and documentation to watch for progress or changes to the skin impairment. Undated facility document titled Skin Condition Review included all nursing staff are responsible for monitoring the effectiveness of implemented interventions and in making necessary changes.	F 684	having the potential to be affected by the same deficient practice: - Facility wide audits will be conducted on current residents with identified physician prescribed skin treatments; will validate routine documentation regarding description of skin impairment and prescribed treatment is completed. 3. Measures and systemic changes made to ensure deficient practice will not recur: - Mandatory re-education for nursing staff on the skin protocol. Documentation audits will be conducted weekly on 10 residents for four weeks; then five residents weekly for eight weeks. Then audits will continue to be conducted on a routine basis to ensure continued compliance. On-going staff mentoring will be conducted as necessary. 4.Facility plans to monitor its corrective actions to ensure the deficient practice is corrected and will not recur: - Facility will facilitate continued compliance by conducting weekly audits for 3 months. Then audits will be conducted on a routine basis with monitoring through the Quality Improvement Process. If quality issues are identified, facility policies and procedures will be reviewed and appropriate interventions will be implemented. 5. Director of Nursing is responsible for correction, implementing interventions and monitoring effectiveness.	

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F 880	Continued From page 3	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		2/21/25

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F 880	Continued From page 4 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify an outbreak of gastrointestinal (GI) illness, implement corrective action to reduce the spread of illness and infections in the facility and report the outbreak to the State Agency (SA). This had the potential to affect all 124 residents in the facility and facility staff.	F 880	F880 1. Corrective action identified for failure to report a GI outbreak to the State Agency; - The facility identified a GI outbreak and initiated the following interventions during the outbreak; facility wide masking, droplet and contact precautions were	

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F 880	Continued From page 5 Findings include: The facility's infection/tracking and monitoring spreadsheet tracked unit name, resident name, room number, admit date, existing infection from previous month(s), infection type, body system of infection, surveillance definition met, symptom(s), onset date, and date symptoms resolved. Review of the spreadsheet from December 1, 2024, through January 21, 2025, revealed the following: Nine residents in the month of December were identified with GI concerns: -8 residents were identified to reside on the Pioneer Village unit with an infection type of gastroenteritis. The date of first onset was 12/3/24 and the date of last symptoms resolved was 12/17/24. Symptoms included emesis, loose stools, and nausea. -1 resident was identified to reside on the Rapid Recovery 2 unit with an infection type of gastroenteritis. The date of first onset was 12/12/24 and the date of last symptoms resolved was 12/17/24. Symptoms included emesis, nausea. Four residents in the month of January were identified with GI concerns: -2 residents were identified to reside on the Garden Cottage unit with an infection type of gastroenteritis. The date of first onset was 1/12/25 and the date of last symptoms resolved was 1/19/25. Symptoms included loose stools and nausea. -2 residents were identified to reside on the Rapid Response 1 unit with an infection type of gastroenteritis. The date of first onset was 1/17/25 and the date of last symptoms resolved	F 880	implemented, increased cleaning and disinfection, separation of group activities, limiting resident to resident interaction to include separate dining areas and affected residents to eat in their room. However, the facility failed to report a GI outbreak to the State Agency. The Infection Preventionist and Nursing management reviewed the facility policy for reporting infectious diseases and determined the policy did delineate the appropriate reporting requirement to prevent further deficient practice. 2. Facility will identify other areas having the potential to be affected by the same deficient practice: - Upon completion of the survey the Infection Preventionist and Nursing Management did an in-depth review of the staff and resident's infection tracking/log with no identified potential reportable outbreaks. 3. Measures and systemic changes made to assure deficient practice will not recur: - Re-education of Management, Directors and Supervisors on resident/employee illness and infection disease reporting requirements. - Weekly summary of all resident and employee illnesses will be reviewed at QI Council for eight weeks. - Upon review of the infection/tracking spreadsheet; it was identified on 2/4/2025 there was a reportable outbreak related to 1 resident and 3 staff with GI symptoms. On 2/4/2025 this was reported to the State Agency. Facility implemented outbreak	

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F 880	Continued From page 6 was blank. Symptoms included loose stools and vomiting. The spreadsheet lacked identification of precautions or interventions implemented in response to the identified infections. A document titled Infection Control dated December 2024, which included analysis of facility infections, identified nine GI nososcomial (facility acquired) infections for the month of December. The section for conclusion/actions was blank. An Infection Control Analysis document was not provided for January 2025. The facility's Employee Illness Log dated December 2024 identified symptoms tracked to include vomiting only, diarrhea only, Cold or Respiratory infection, Influenza/COVID symptoms, positive for influenza, positive for COVID-19, C-Diff (Clostridiodes difficile, a bacterial infection that causes diarrhea and inflammation of the colon), pink eye, GI, skin issues, strep throat, mono (Mononucleosis-a contagious viral illness), other medical, ill child/family, and personal. The number of infections were tracked by unit or department which included Pioneer Village, Garden Cottage, Rapid Recovery 1, Rapid Recovery 2, Activities, Therapy, Dietary, Social Service, Housekeeping & Laundry, Maintenance, and On-call/Support Staff. Review of the log revealed the following: Twenty-eight staff were identified with GI concerns in the month of December: -1 staff member from Pioneer Village and 1 staff member from the Activity department were identified with diarrhea only. -11 staff from Pioneer Village, 7 staff from Garden	F 880	interventions per facility protocol. 4. Facility plans to monitor its corrective actions to ensure the deficient practice is corrected and will not recur: - Summary of infection illnesses will be reviewed weekly and monitored through the Quality Improvement Process. If quality issues are identified, facility policies and procedures will be reviewed and appropriate interventions will be implemented. 5. Director of Nursing and Infection Preventionist are responsible for correction, implementing interventions and monitoring effectiveness.	

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F 880	Continued From page 7 Cottage, 6 staff from Rapid Recovery 1, 6 staff from Rapid Recovery 2, 1 staff from Housekeeping & Laundry and 2 on-call/support staff were identified with GI concerns. The Employee Illness Log for the month of January was requested but not provided. The log lacked identification of dates of illness, resolution of employee symptoms, return to work criteria met or any precautions or interventions implemented to reduce the spread of infections in the facility. Review of the Weekly Quality Council Minutes dated December 31, 2024, January 7, 2025, and January 14, 2025, indicated infection trends/patterns were reviewed and discussed and revealed the following: -12/31/24: identified eight residents with GI symptoms with 8 residing on one wing. -1/7/25: indicated GI cases stabilized. -1/14/25: nososcomial infections/rates-increase in GI infection in December. The minutes did not address employee illnesses or identify actions taken by the facility to address the outbreak or concerns. During interview on 1/23/24 at 12:00 p.m., the infection preventionist (IP) stated she obtained information for infection control surveillance from the nursing staff, case managers, and resident chart documentation to identify potential infections and look for patterns. IP reviewed the facility infection control surveillance logs and verified the resident and employee infections as listed above. She stated infection prevention information was reviewed daily at the interdisciplinary team meeting, weekly on	F 880		

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F 880	Continued From page 8 Tuesdays during Quality council meetings and monthly during Quality Assurance and Performance Improvement meetings. She denied any recent outbreaks in the facility, however, confirmed there had been a pattern of eight residents on the Pioneer Village unit with GI symptoms beginning in December. She logged the information on her spreadsheet, made sure the residents were on droplet and contact precautions and indicated the precautions could be discontinued after the resident was asymptomatic for 72 hours. She had been concerned about the potential the GI symptoms were norovirus (a group of viruses that can cause gastroenteritis, an inflammation of the stomach and intestines) and spoke with the facility nurse practitioner regarding testing. However, the nurse practitioner (NP) had told her she didn't think the local hospital performed the test. She did not contact the hospital herself to confirm testing availability. She denied any outbreak of food-borne illness in the facility but stated food-borne illness went hand in hand with a GI outbreak. If an outbreak occurred, she would look to see if there was something in common the residents ate and talk with the dietary manager regarding dietary employee GI illness. However, she had not spoken to any of the dietary staff in December regarding GI illness and was only aware of three staff with respiratory illness. After this discussion she stated she would consider eight residents on one unit an outbreak. She denied any action was taken to prevent the spread of GI illness to other units of the facility or to employees, outside of placing the symptomatic residents under droplet and contact precautions. No testing of the resident for the infectious organism occurred, no education to staff was provided and the outbreak was not reported the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245330	A. BUILDING _____ B. WING _____	C 01/23/2025

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F 880	Continued From page 9 state agency. During interview on 1/23/25 at 1:38 p.m., nurse practitioner (NP) stated she was aware of multiple residents and staff with reported GI symptoms in the month of December. NP stated she considered 8 residents residing on the same unit, with the same reported symptoms, as an outbreak. She was unsure of how many staff were affected with GI symptoms but that would be taken into consideration as well. Residents were placed in contact/droplet precaution and NP denied further action regarding the GI illness in the facility. During interview on 1/23/25 at 12:35 p.m., the director of nursing was unaware of the pattern of GI illness in the facility but stated eight residents on one unit would and could be looked at as an outbreak. Her expectations were for the IP to address the outbreak per the facility policy to include placing the residents in the appropriate precautions, the use of isolation bins, signs alerting staff and visitors, hand hygiene, the affected residents eating in their room and reporting the outbreak to the SA, if appropriate. She would have expected the IP follow up with the laboratory to have testing due to the potential type of infection. If the outbreak was contagious, it would be important to identify what it is to help stop the spread and determine a treatment. As well as protect the health of the other residents and make sure we are following current guidelines. The Management of Gastrointestinal Illness/Outbreak policy last reviewed 6/24, directed it was policy of this facility that once loose, watery stools have been evaluated,	F 880		

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F 880	Continued From page 10 prevention and outbreak management measures must be followed. The policy defined Gastroenteritis as inflammation of the stomach and small and large intestines. Viral gastroenteritis (norovirus) is an infection caused by a variety of viruses that result in vomiting or diarrhea. It is often called the 'stomach flu'. The policy further defined an outbreak as three or more cases of diarrhea on one specific unit, and directed staff to discontinue group activities where sick and well residents would be together, group activities should be kept to a minimum or postponed until outbreak is over; minimize the flow of staff between sick and well residents; staff should be assigned to work with either well or sick residents, but not care for both groups; a sign will be posted at the entrances of the facility explaining to visitors/friends that the facility's residents are experiencing GI symptoms; the infection preventionist/designee will inform the medical director and request orders for cultures on 2-3 residents who are experiencing symptoms; the infection preventionist/designee will call the Department of Health and inform them of the suspected outbreak and do updates as necessary; the clinical managers/supervisors, under the direction of the director of nursing and the infection preventionist/designee, will assist with in-servicing the staff on the criteria, guidelines, and recommendations; the infection preventionist/designee will report resolution to appropriate public health agencies and gather collected data for final narrative report.	F 880		

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:
	245330	A. BUILDING: **01 - MAIN BUILDING** B. WING _____	**1/22/2025**

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on oberservation and staff interview, the facility failed to maintain the means of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, and 7.1.10.1. These deficient findings could have a patterned impact on residents within the facility. Findings include: 1. On 01/22/2025 between 10:30 AM and 1:30 PM, it was revealed by observation that the exit door in the Tea Cup Dining Room was obstructed and could not be opened all the way. This violation was corrected at the time of discovery. 2. On 01/22/2025 between 10:30 AM and 1:30 PM, it was revealed by observation that the exit door in the Vineyard Dining room was difficult to open and required excessive force to open the door. This violation was corrected at the time of discovery. An interview with the Maintenance Director verified these deficient findings at the time of discovery.
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Saftey Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection,

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245330	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING** B. WING _____	DATE SURVEY COMPLETE: **1/22/2025**

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K 353	Continued From Page 1 Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(5). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 01/22/2025 between 10:30 AM and 1:30 PM, it was revealed by observation that sprinkler heads in the B10 Spa Room were covered with lint and dust. This violation was corrected at the time of discovery. An interview with the Maintenance Director verified this deficient finding at the time of discovery.
K 930	Gas Equipment - Liguid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper storage of liquid oxygen equipment per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 01/22/2025 between 10:30 AM and 1:30 PM, it was revealed by observation that two liquid oxygen base reservoir containers were being stored in resident room 143. This violation was corrected at the time of discovery. An interview with the Maintenance Director verified this deficient finding at the time of discovery.

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K 000	INITIAL COMMENTS An annual Life Safety Code Survey was conducted, on 01/22/2025, 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 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care, and the 2012 edition of the Health Care Facilities Code (NFPA 99). The facility was inspected as one building: 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 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	K 000		

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

Electronically Signed | 02/12/2025

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

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K 000	Continued From page 1 II(111) construction. Because the original building and the additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. 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 131 beds and had a census of 124 at the time of the survey. The requirements at 42 CFR, Subpart 485.623 (d) are NOT MET.	K 000		