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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: IV6L

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**
(L4) **520 FIRST STREET NORTHEAST**
(L5) **SARTELL, MN** (L6) **56377**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/06/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (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**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **165** (L18)
13.Total Certified Beds **165** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

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 Date :
Teresa Ament, Unit Supervisor 10/15/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/15/2021 (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
____ 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)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 15, 2021

CMS Certification Number (CCN): 245330

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 4, 2021 the above facility is certified 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 15, 2021

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

RE: CCN: 245330
Cycle Start Date: August 16, 2021

Dear Administrator:

On September 9, 2021, we notified you a remedy was imposed. On October 6, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 4, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 24, 2021 be discontinued as of October 4, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 9, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 24, 2021. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 15, 2021

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

Re: Reinspection Results
Event ID: IV6L12

Dear Administrator:

On October 6, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 6, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IV6L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00627

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(L1) **245330**
2.STATE VENDOR OR MEDICAID NO.
(L2) **943188800**

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: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/16/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (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**	

FISCAL YEAR ENDING DATE: (L35)
06/30

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To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

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 Date :
Colleen Johnson HFE - NE II 09/20/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/12/2021 (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
____ 2. Facility is not Eligible
(L21)

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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)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
September 9, 2021

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

RE: CCN: 245330
Cycle Start Date: August 16, 2021

Dear Administrator:

On August 16, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On August 13, 2021, the situation of immediate jeopardy to potential health and safety cited at F 880 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 24, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 24, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 24, 2021,(42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 24, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 February 16, 2022 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 08/16/2021

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 8/9/21, through 8/16/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/9/21, through 8/16/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED H5330055C (MN67118), related to the deficiency at F880. The following complaints were found to be SUBSTANTIATED H5330056 (MN69746), and H5330054C (MN66857) however NO deficiencies were cited due to actions implemented by the facility prior to survey: AND/OR The following complaints were found to be UNSUBSTANTIATED: H5330046C (MN52532) H5330047C (MN53249) H5330048C (MN53250)	F 000		

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

Electronically Signed | 09/17/2021

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 08/16/2021

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
F 000	Continued From page 1 H5330049C (MN57205) H5330050C (MN59332) H5330051C (MN65608) H5330052C (MN66656) H5330053C (MN66667) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. The survey resulted in an Immediate Jeopardy (IJ) at F880 when the facility filed to ensure a newly readmitted unvaccinated resident, R213, was appropriately quarantined. The facility also failed to ensure proper use of personal protective equipment (PPE) for staff including failure to ensure staff working with residents in quarantine use N95's as appropriate when they had been fit tested and provided the appropriate supplies. The IJ began on 8/12/21, and the immediacy was removed on 8/13/21.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		9/27/21

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F 657	Continued From page 2 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a baseline care plan was provided in writing for 2 of 5 residents and/or their representatives (R87, R96) reviewed for care plans. Findings include: R87's Detailed Summary report printed on 8/13/21, indicated R87's diagnoses included sequela of nontraumatic intracranial hemorrhage (bleeding inside the skull), surgical aftercare following surgery on the nervous system (brain surgery), convulsions, encounter for gastrostomy (a feeding tube inserted through the skin and	F 657	F657 1. Corrective action for resident identified in deficiency: Re educated baseline care plan policy immediately with RN CM; baseline care plan completed and in compliance for R87 on 7/09/2021 however was not offered/provided to identified resident timely. RN CM spoke with resident representative reviewed care plan and offered. R96 baseline care plan completed within regulatory compliance on 4/19/2021 but was not provided timely.	

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F 657	Continued From page 3 stomach wall), and atherosclerotic heart disease (build up of fats and cholesterol in and on the artery walls causing arteries to narrow and blocking blood flow). R87's admission Minimum Data Set (MDS) dated 7/15/21, identified R87 had severely impaired cognition, and was totally dependent for all activities of daily living (ADL). In addition R87 was dependent on tube feeding for nutrition. R87's care plan started on 7/16/21, addressed the minumum required elements for effective and person-centered care. On 8/10/21, at 11:28 a.m. family member (FM)-A and FM-B were interviewed. FM-A and FM-B stated they could not recall attending any care conference or being offered a copy of the baseline care plan in the first couple of days after R87's admission. FM-A could not recall any staff asking him anything about R87's daily preferences. During an interview on 8/13/21, at 9:08 a.m. the director of social services (SW)-A stated there should have been a progress note about the initial care conference and care plan in R87's progress notes. SW-A reviewed the progress notes but could not find any notes on the care conference and baseline care plan. SW-A stated they do not offer residents and resident representatives a copy of the baseline care plan but the resident and/or resident representative could ask for copies of anything they want. During an interview with registered nurse (RN)-A on 8/13/21, at 9:58 a.m. RN-A stated she did not document that she provided a written care plan to	F 657	2. Facility will identify other residents with potential to be affected: The facility will identify and audit all resident□s admitted to the facility for 2 weeks starting 9/10/21 thru 09/24/2021. Beginning on 9/25 4 new patient records will be audited weekly for one month to ensure distribution of baseline care plan to patient/representative. The audits will be conducted on a routine basis to ensure continued compliance. Sample will be expanded as deemed necessary. 3. Measures and systemic changes made to ensure deficient practice will not reoccur: Mandatory re-education of baseline care plan policy provided to responsible staff. Education included intent of baseline care plan, policy and expectations. Competency completed. 4 new patient records will be audited weekly for one month to ensure compliance with distribution of baseline care plan to patient/representative. On-going staff mentoring will be conducted as deemed necessary. 4. The facilities plan to monitor performance, measure effectiveness and integrate into the quality assurance program: The facility will assure continued compliance by auditing 4 new patient records weekly for one month to ensure distribution of baseline care plan to	

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F 657	Continued From page 4 R87 and/or their representative. R96's Detailed Summary report printed on 8/13/21, identified R96's diagnoses included nondisplaced fracture of upper end of left humerus (broken arm), chronic interstitial cystitis (chronic inflammatory condition of the bladder), urinary retention, diabetes mellitus type II, anxiety, depression, and dementia. R96's care plan started 5/4/21, addressed the minumum required elements for effective and person-centered care. R96's quarterly MDS dated 7/24/21, indicated R96 was moderately cognitively intact and required extensive assistance with ADLs. In an interview with R96 on 8/10/21, at 10:53 a.m. R96 stated she could not recall receiving any written care plan. During an interview with SW-A on 8/13/21, at 9:01 a.m. SW-A reviewed R96's progress notes but could not find documentation that the care conference was completed and that a copy of the baseline care plan was provided to the resident and/or the resident representative. -at 9:43 a.m. the director of nursing (DON) stated nursing "always" gives the baseline care plan to the resident and their families. -at 11:16 a.m. the DON verified it was her expectation that staff would enter a progress note and include that the base line care plan was offered to the resident and/or their representative in writing.	F 657	patient/representative. If noncompliant practice is observed immediate re education and correction will be done at time of audit. Thereafter audits will be conducted on a routine basis and monitored through the Quality Assurance Improvement Process. If quality issues are identified, facility policies and procedures will be reviewed and appropriate interventions will be implemented. DON and nursing leadership will be responsible for correction, monitoring, and implementing. DON responsible for continued compliance. Date of Correction 9-27-2021	

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F 657	Continued From page 5 The facility policy Baseline Care Plan review date 6/21, directed staff would develop a baseline care plan within 48 hours of admission. Along with the baseline care plan is a summary of the care plan that is provided to the resident and representative in language that can be understood. The policy directed staff would document in the clinical record that the baseline care plan was given to the the resident and representative.	F 657		
F 880 SS=K	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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		9/27/21

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F 880	Continued From page 6	F 880		

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;
(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

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F 880	Continued From page 7 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to quarantine a resident (R213) who was readmitted and not vaccinated for COVID-19. These practices resulted in an immediate jeopardy (IJ) due to the increased risk for transmission of COVID-19. Further, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 related to the proper utilization of personal protective equipment (PPE) for 1 of 4 resident (R213) reviewed for transmission based precautions (TBP). In addition, the facility failed to ensure isolation gowns were not reused for 1 of 4 residents (R311) reviewed for infection control practices. Further, the facility failed to ensure a catheter drainage bag was kept off the floor to prevent contamination for 1 of 3 residents (R5) who utilized indwelling urinary catheters. The IJ began on 7/30/21, when R213 was re-admitted from the hospital and the facility failed to quarantine R213 who had not been vaccinated for COVID-19. The facility failed to implement transmission-based precautions (TBP) utilizing all necessary personal protective equipment (PPE) including N95 respirators, for R213. The facility administrator and director of nursing (DON) were notified of the IJ on 8/12/21, at 4:50 p.m. The IJ was removed on 8/13/21, at 5:09 p.m. but noncompliance remained at the lower scope and severity level of E pattern, no actual harm with potential for more than minimal harm that is not IJ. Findings include:	F 880	Preparation, submission and implementation of this plan of correction does not constitute an admission of our agreement with the facts and conclusions in the statement of deficiencies. The facility has appealed the alleged deficiency F880. This plan of correction is prepared and executed as a means to continuously promote and improve quality of care and compliance with all applicable state and federal regulatory requirements and constitutes the facility□s compliance. In response to the stated citation F880 Country Manor Health Care and Rehab Center has taken the following actions: F880 1) Corrective action for resident identified in deficiency: On 8/12/21 resident was immediately brought to his room and 1:1 supervision was provided until he went to bed for the night. It is noted that resident sleeps well and has not had any falls during the nighttime hours. All staff entering the room wore appropriate PPE including (isolation gown, eye protection, gloves and N95 respirator). Quarantine (contact/droplet) were removed on 8/13/21 r/t being in the facility for 14 days. Any staff that had the potential to enter quarantine rooms and had not yet been fit tested were fit tested during their 1st shift starting the evening of 8/12/21. The facility has changed its Management of Suspected or Confirmed Corona Virus	

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F 880	Continued From page 8 Current CDC guidance dated 2/10/21, directed health care workers who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. CMS COVID-19 Long Term Care Facility Guidance, dated 4/2/20, directed nursing homes to immediately ensure they were complying with all Centers for Medicare & Medicaid Services (CMS) and CDC guidance related to infection control which included the use of standard, contact and droplet precautions. R213's Detailed Summary dated 8/16/21, indicated R213 was readmitted to the facility on 7/30/21, and included diagnoses of Parkinson's disease, dementia, repeated falls, left scapula, multiple rib fractures, and a wedge compression fracture. R213's admission Minimum Data Set (MDS) dated 7/30/21, indicated R213 had severe cognitive impairment, and required extensive assist with bed mobility, transfers, dressing, toileting, one assist with eating and personal hygiene. R213's MDS further indicated falls prior to admission, in the last 2-6 months prior to admission w/fracture and 2 falls since admission R213's updated care plan dated 8/10/21, indicated R213 was at risk for falls, on the falling star program, and was to be in his doorway or at the nurses desk to maintain close observation. R213's care plan further indicated R213 was not vaccinated for COVID-19 and was at risk for	F 880	(COVID-19) policy to include the following Isolate all admitted and readmitted residents, regardless of diagnosis, fall risk, and/or cognition, in their room for 14 days unless the resident has had COVID-19 in the past 90 days and/or they are fully vaccinated. Droplet and Contact precautions will be utilized for 14 days from admission or readmission for these circumstances. The facility will also be doing fit testing for employees on the use of N95 respirators upon hire if that employee will be in direct contact with quarantined residents or will have the need to enter an isolation room (i.e., nursing, therapy, social services, activities, housekeeping). Staff working on the afternoon of 8/12/2021 were educated on changes in policy immediately and all other staff were educated prior to the start of their next shift. 9/15/2021 Additional education with competency was implemented. Deficiencies, Plan of Correction (POC), Directed Plan of Correction (DPOC), RCA, PIP and Infection Control consultant□s credentials were reviewed with Governing Board on 09/16/2021. Meeting held with IC consultant, VP of CC/Rehab, DON, Directors of Clinical Rehab, Clinical Planning/ICP and Dir. Quality reviewed 2567, POC,DPOC, PIP, RCA. Facility has fulltime ICP on staff and is involved in daily operations. Medical Director has been updated on deficiencies and all measures	

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F 880	Continued From page 9 COVID-19. R13's care plan directed was to wear a cloth face mask if tolerated when staff was providing care or within six feet for R213 or when R213 was outside of R213's room. R213's care plan directed Therapeutic Recreation would provide in room leisure activities. R213's physician orders dated 8/10/21, indicated R213 was allowed out of his room during the 14 day observation period which began 7/30/31, and ended 8/13/21. On 8/9/21, at 2:21 p.m. signage was observed on R213's door, which indicated R213 was on droplet and contact precautions, and required an isolation gown, mask, eye protection, and gloves before entering R213's room. R213 was not observed in room at that time. On 8/9/21, at 5:10 p.m. R213 sat at the nurse's station on the Rapid Recovery unit., and R213's mask did not cover R213's nose or mouth but was down around R213's chin. Staff and residents were observed to walk by R213 less than six from R213. R213 while R213 sat in the main pathway by the nurses desk. On 8/9/21, at 7:05 p.m. registered nurse (RN)-G stated R213 was on quarantine for 14 days because R213 was readmitted from the hospital and had not received the COVID 19 vaccine. RN-G stated before entering R213's room PPE needed was a gown, N95 mask, gloves, and eye protection. On 8/9/21, at 7:09 p.m. R213 sat outside of the threshold of his room and ate supper on the tray table. During supper meal, nursing assistant (NA)-F was observed to stand less than six feet	F 880	implemented to ensure regulatory compliance. 2) Facility will identify other residents with the potential to be affected: The facility will identify other residents who are on quarantine for either 14 day admission/readmission precautions or suspected/confirmed COVID-19 infection: Audits will be conducted to ensure the resident has stayed in room as per policy. This audit will also include PPE and N95 audits that will audit staff for use of N95 respirators when entering these rooms (quarantine rooms) The audits will include if these staff have been fit tested. Audits will be conducted by nursing leadership staff on all shifts daily for one week. Sample will be expanded as deemed necessary. Auditing to verify the placement of each new admission and resident location daily to ensure transmission based precautions (TBP) are appropriately implemented when cohorting residents for one month. The facility will decrease these audits as compliance for TBP are achieved. 3) Measures and systemic changes made to ensure deficient practice will not recur: Mandatory education has been provided to all staff starting 8/12/2021 and will continue to be done upon hire. This education will include the aforementioned policy changes. Additional education with competency started 9/15/2021. N95 fit	

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F 880	Continued From page 10 from R213 outside of R213's doorway and assisted R213 with supper by handing R213 his fork. NA-F wore eye protection and a surgical mask; but did not wear a gown, gloves, or N95 respirator. RN-D approached NA-F and instructed NA-F to put an isolation gown and gloves on when working with R213. On 8/9/21, at 7:10 p.m. NA-F verified she should have donned an isolation gown and gloves while assisting R213 with supper. On 8/9/21, at 7:11 p.m. RN-D stated R213 was on a 14-day quarantine and droplet precautions because R213 was readmitted from the hospital and had not received the COVID-19 vaccine. RN-D stated staff should wear an isolation gown, gloves, eye protection, and a mask when working with residents on quarantine. RN-D verified she instructed NA-F to put on an isolation gown and gloves while supervising R213 during supper. On 8/10/21, at 8:36 a.m. NA-G sat with R213 outside of the threshold of R213's doorway while R213 ate breakfast in arm's reach of R213. NA-G did not wear a gown, gloves or N95 mask. On 8/10/21, at 5:44 p.m. R213 sat at the nurses station on the Rapid Recovery unit, and R213's mask did not cover R213's nose or mouth but was down around R213's chin. On 8/11/21, at 12:17 p.m. R213 sat in his wheelchair in the threshold of his room and ate lunch while speech therapist (ST)-A sat next to him. ST-A wore a clear face shield, surgical mask, and gown. On 8/11/21, at 3:38 p.m. R213 sat at the Rapid	F 880	testing and education will also be completed upon hire for appropriate staff. Audits will be conducted by nursing leadership staff on all shifts daily for one week. After that, audits will be conducted on a routine basis to ensure continued compliance. Auditing to verify the placement of each new admission and resident location daily to ensure transmission based precautions (TBP) are appropriately implemented when cohorting residents for one month. The facility will decrease these audits as compliance for TBP are achieved. On-going staff mentoring will be conducted as necessary. Audit tool revised and implemented to determine continued compliance. 4) The facilities plan to monitor performance, measure effectiveness and integrate into quality assurance program: Audits will be conducted by nursing leadership staff on all shifts daily for one week If non complaint practice is observed immediate re education and correction will be done at time of audit. After that audits will be conducted on a routine basis to ensure continued compliance. Auditing to verify the placement of each new admission and resident location daily to ensure transmission based precautions (TBP) are appropriately implemented when cohorting residents for one month. The facility will decrease these audits as compliance for TBP are achieved. All audits conducted will be monitored through the Quality Assurance Process. If	

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F 880	Continued From page 11 Recovery unit nurses' station, and listened to country music, and wore a surgical mask around his mouth and nose. LPN-B only wore a surgical mask, and eye protection, and knelt next to R213 and sang to R213. On 8/12/21, at 8:41 a.m. R213 sat in his wheelchair outside the threshold of his doorway, wore a clear face shield without a mask. On 8/12/21, at 9:34 a.m. RN-E stated not all staff had been fit tested for N95 respirators and the facility tried to catch staff as they could. RN-E stated if staff were not N-95 fit tested, staff should not enter isolation rooms. RN-E stated she did not have a current plan to ensure staff were fit tested for use of an N95 respirator. On 8/12/21, at 9:44 a.m. NA-D and NA-E were observed to wear face shields, gowns, gloves, and surgical masks as they escorted R213 to his room from the Rapid Recovery nurses' station. They entered the room and closed the door. On 8/12/21, at 9:48 a.m. NA-D and NA-E exited R213's room and wore surgical masks and face shields. On 8/12/21, at 9:50 a.m. NA-D stated she assisted R213 with a transfer into bed. NA-D stated she did not wear an N95 when she assisted R213 into bed and should have worn one. NA-D stated she had been fit tested for N95. Review of facility documentation however, indicated NA-D had not been N95 fit tested. On 8/12/21, at 9:59 a.m. NA-E stated she had assisted R213 into bed and verified she did not wear an N95 mask, and only wore a surgical	F 880	noncompliant practice is observed immediate re education and correction will be done at time of audit. If issues are identified, facilities policies and procedures will be reviewed and appropriate interventions will be implemented. DON and Infection Preventionist are responsible for correction, monitoring, effectiveness and implementing interventions. Correction date 9/27/2021 F880 1) Corrective action for resident identified in deficiency: The identified residents urinary drainage bags were immediately removed from the floor and hung up off of the floor and below level of the bladder. CNAs and floor nurses were re-educated and counseled regarding urinary drainage bag care and placement and expressed understanding of Country Manor Urinary Catheter Care Policy. 2) Facility will identify other residents with the potential to be affected: The facility will identify all residents who have a urinary catheter. Audits will be conducted by nursing leadership staff on all shifts daily for one week for correct drainage bag placement. Sample will be expanded as deemed necessary 3) Measures and systemic changes made to ensure deficient practice will not recur: Mandatory re-education will be completed by all nursing staff and will include re-education on the Catheter Care Policy	

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	245330	A. BUILDING _____ B. WING _____	C 08/16/2021

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F 880	Continued From page 12 mask when she assisted R213 into bed. NA-E stated she had not been fit tested to wear an N95 respirator. On 8/12/21, at 11:56 a.m. physical therapist (PT)-A was observed being fit tested for an N95 respirator in the education room. At 8/12/21, at 11:57 a.m. PT-A exited the education room and stated he was just fit tested for a N95 respirator and was informed about the testing that day. PT-A stated he had worked with residents in quarantine rooms, and prior to that had not been N95 fit tested. On 8/12/21, at 12:29 p.m. RN-E provided list of employees and indicated the ones who were not N95 fit tested. The facilities staff scheduled was reviewed and compared to the list of employees who were not N95 fit tested, revealed on the night shift for 8/9/21 and 8/11/21, none of the 12 staff who worked, had been fit tested for use of an N95 mask. On 8/12/21, at 2:29 p.m. DON stated it was the expectation staff who worked with residents on quarantine to be N95 fit tested and wear an N95 respirator. The DON further stated if staff were not fit tested for an N95 respirator or had medical exclusions to wear an N95 respirator, staff should not enter any rooms on quarantine. On 8/13/21, at 11:44 a.m. RN-F stated R213 was on Falling Stars due to R213's impulsiveness, poor judgement, and subsequent falls and required to be in line of sight. RN-F stated R213 was on quarantine because R213 was a readmission, was unvaccinated and required a 14-day quarantine. RN-F stated R213 was allowed out of his room because R213 needed to	F 880	and placement of drainage bags. Audits will be conducted by nursing leadership staff on all shifts daily for one week. After that audits will be conducted on a routine basis to ensure continued compliance. On-going staff mentoring will be conducted as deemed necessary. 4) The facilities plan to monitor performance, measure effectiveness and integrate into the quality assurance program: The facility will assure continued compliance through audits completed by nursing leadership staff on all shifts daily for one week, then weekly audits for 1 month. If noncompliant practice is observe immediate re education and correction will be done at time of audit. The audits will be conducted on a routine basis 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. DON and Infection Preventionist are responsible for correction, monitoring effectiveness and implementing interventions. Date of correction 9/27/21 F880 1) Corrective action for resident identified in deficiency: Upon hearing of concern of potential reuse of an isolation gown, nursing leadership immediately re-educated and counseled the RN in question regarding the proper use of PPE and not reusing isolation gowns. RN verbalized	

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F 880	Continued From page 13 be in line of sight of staff because R213 would get out of his wheelchair and attempt to stand. RN-F stated there were no designated staff assigned to R213 for one on ones, and staff would just tag team. RN-F stated sometimes RN-F would sit at the nurse's station and other times R213 sat in his doorway so staff could see R213. The deficient practice was corrected on 8/13/21, at 5:09 p.m. after the facility developed and implemented corrective action to include updating the Management of Suspected or Confirmed Corona Virus (COVID-19) policy to include: quarantine all admitted and readmitted residents regardless of diagnosis, fall risk, and/or cognition in their rooms for 14 days unless they are fully vaccinated. The policy was updated to also include, the facility would also be doing fit testing for employees on the use of N95 respirators upon hire if that employee will be in direct contact with residents or will have the need to enter a quarantine room (i.e., nursing, therapy, social services, activities, housekeeping). Staff working 8/13/21, were educated on the Removal Plan and updated Management of Suspected or Confirmed Corona Virus (COVID-19) policy. Staff signed acknowledgment they read and understood the memo on the Removal plan and policy changes prior to their scheduled shift. Any appropriate staff (i.e. nursing, therapy, social services, activities, housekeeping) that had the potential to enter quarantine room were fit tested 8/13/21, prior to entering quarantine rooms. Department managers would be responsible for identifying appropriate employees that require fit testing will communicate to their employees the time and location of fit testing. On 8/13/21, between 4:00 p.m. and 5:04 p.m. nine RNs, seven LPN's, 13 NA's, four staff in social services, one music	F 880	understanding of this protocol and recall of previous education. 2) Facility will identify other residents with the potential to be affected: The facility will identify other residents who are on quarantine for either 14-day admission/readmission precautions or suspected/confirmed COVID-19 infection. Weekly PPE audits will be conducted to audit staff for proper donning and doffing of PPE when entering/exiting these residents rooms as well as proper disposal of PPE. The PPE audit has been revised to include proper disposal of PPE in trash receptacles. Audits will be conducted by nursing leadership staff on all shifts daily for one week. Sample will be expanded as deemed necessary. 3) Measures and systemic changes made to ensure deficient practice will not recur: Mandatory re-education for all staff will be conducted and will include COVID-19 PPE policies and procedures including proper disposal of PPE after use. Audits will be conducted by nursing leadership staff on all shifts daily for one week. After that, audits will be conducted on a routine basis to ensure continued compliance. On-going staff mentoring will be conducted as necessary. Revised audit tool will be implemented to determine continued compliance. 4)The facilities plan to monitor performance, measure effectiveness and integrate into quality assurance program: Audits will be conducted by nursing leadership staff on all shifts daily for one	

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F 880	Continued From page 14 technician, three housekeepers, six therapists, one maintenance staff, nine activity staff, nine dietary staff, and one volunteer coordinator were interviewed and verified the above education and verified they were N95 fit tested. The facility policy Management of Suspected or Confirmed Corona Virus (COVID-19) revised 8/13/21, directed to quarantine all admitted and readmitted residents regardless of diagnosis, fall risk, and/or cognition in their rooms for 14 days unless they are fully vaccinated. The policy was updated to also include, the facility would also be doing fit testing for employees on the use of N95 respirators upon hire if that employee will be in direct contact with residents or will have the need to enter a quarantine room. R311's Profile Face Sheet indicated R311 was admitted on 8/5/21. R311's Resident Diagnosis List printed 8/13/21, indicated R311's diagnoses included hemiplegia (paralysis of one side of the body) of left nondominant side, dysphagia (difficulty swallowing food and liquids), diabetes mellitus type II, depression, morbid obesity, and ateriovenous malformation of cerebral vessels (an abnormal connection of blood vessels in the brain or spine). R311's care plan initiated on 8/5/21, directed R311 would remain on a 14 day room restriction upon admission or readmission to the facility during the pandemic. On 8/9/21, at 6:27 p.m. the dinner tray service to rooms was observed on the Pinecone Lodge unit. Nursing assistant (NA)-A was observed donning personal protective equipment (PPE) prior to	F 880	week. If noncompliant practice is observed immediate re education and correction will be done at time of audit. The audits will be conducted on a routine basis and monitored through the Quality Assurance Process. If issues are identified, facilities policies and procedures will be reviewed and appropriate interventions will be implemented. DON and Infection Preventionist are responsible for correction, monitoring effectiveness and implementing interventions. Date of correction: 9/27/2021	

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F 880	Continued From page 15	F 880		

bringing R311 a meal tray. Registered nurse (RN)-B could be heard talking to NA-A from inside R311's room. RN-B stated she was going to hang her isolation gown in the room to use the next time she needed to enter R311's room. When RN-B exited the room she was interviewed, RN-B verified she was unsure if re-using an isolation gown was acceptable practice but had been in/out of the room at least four times already. RN-B verified she was re-using her isolation gown, she verified the facility did not have a shortage on isolation gowns.

On 8/9/21, at 6:36 p.m. RN-B verified it was not acceptable practice to hang isolation gowns in the quarantine room and continue to use them.

On 8/13/21, at 11:34 a.m. the director of nursing (DON) verified it was not acceptable practice for staff to re-use isolation gowns.

The facility policy titled Personal Protective Equipment for Resident with Confirmed or Suspected COVID-19 directed staff to discard the isolation gown in a waste container or hamper after removing.

R5's Detailed Summary Sheet printed 8/12/21, indicated R5's diagnoses included a history of urinary tract infections, severe sepsis with septic shock (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues), acute kidney failure, chronic kidney disease, diabetes, and retention of urine.

R5's quarterly Minimum Data Set (MDS) assessment dated 5/5/21, indicated R5 had a

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F 880	Continued From page 16	F 880		

severe cognitive impairment, had an indwelling catheter, had a urinary tract infection (UTI) in the past 30 days and sepsis. R5 required extensive assist with toileting cares.

R5's physician orders dated 8/12/21, included:
-Change specified catheter monthly for retention of urine
-Do not irrigate Foley catheter, change as needed for leaking or decreased urinary output using similar sized catheter. Change catheter and tubing prior to obtaining a urinalysis/urine culture sample. May attach leg bag when out of bed then re-attach to straight drainage when in bed. Flush only when instructed by urology, then use a regular flush when indicated.
-Foley catheter cares every shift

R5's care plan initiated 6/9/21, identified R5's risk of infections related to the catheter, and directed catheter cares and changes, and for catheter bag to be hung below level of bladder at all times, but lacked directives to ensure catheter drainage bag was kept off the floor.

R5's nursing assistant (NA) worksheet/communication dated 8/11/21, directed NA's to provide catheter cares every shift and as needed, but lacked directives for positioning of catheter and to ensure R5's catheter drainage bag was kept off the floor.

R5's Interdisciplinary Notes dated 8/11/21, for care conference on 8/10/21, indicated R5 had been hospitalized from 6/6/21, through 6/9/21, with a UTI and sepsis.

On 8/9/21, at 3:12 p.m. R5 was observed lying in bed with his catheter drainage bag sitting on the

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F 880	Continued From page 17	F 880		

privacy bag which was on the floor.

On 8/12/21, at 8:20 a.m. R5 was observed to be lying in bed, with his catheter drainage bag hanging from the bottom right side of his bed, in a cloth privacy bag, touching the floor.

On 8/12/21, at 8:34 a.m. NA-C entered R5's room to do morning cares, including catheter cares. NA-C verified R5's catheter drainage bag and cloth privacy bag were sitting on the floor and should have been hung to keep off the floor. NA-C stated the catheter privacy bag was wet and needed to be changed. NA-C washed up R5, provided catheter cares using proper infection control practices, and dressed R5. NA-C stated it appeared that R5's catheter was getting clogged, as it had some sediment in the tubing, so would tell the nurse. NA-C transferred R5 into the wheelchair and hung the catheter drainage bag under the wheelchair, off the floor. NA-C went to inform licensed practical nurse (LPN)-A that R5's catheter drainage bag had been on the floor and to get a privacy bag to cover R5's catheter drainage bag.

On 8/12/21, at 9:20 a.m. LPN-A changed R5's catheter drainage bag, placed it in a clean privacy bag, and hung it under R5's wheelchair. LPN-A verified R5's catheter tubing had sediment in it and stated she did not like that, so would talk to R5's case manager. LPN-A verified the catheter drainage bags, even when in a privacy bag, should not be hanging so it touched the floor due to risk of infection.

On 8/12/21, at 10:27 am. registered nurse (RN)-C verified catheter drainage bag and privacy bag should not be touching the floor.

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F 880	Continued From page 18 On 8/12/21, at 2:44 p.m. director of nursing (DON) verified catheter drainage bags should be kept off the floor to prevent cross-contamination and risk of infection. The facility policy and procedure for Urinary Catheter Care reviewed 6/21, lacked directives to ensure the catheter drainage bag and tubing were hung so they were not touching the floor or contaminated surface.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 9, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: IV6L11

Dear Administrator:

The above facility was surveyed on August 9, 2021 through August 16, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Susan Frericks, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 8/9/21, through 8/16/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by:	21390		9/27/21

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	00627	A. BUILDING: _____ B. WING _____	C 08/16/2021

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21390	Continued From page 3 Based on observation, interview, and document review, the facility failed to quarantine a resident (R213) who was readmitted and not vaccinated for COVID-19. Further, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the transmission of COVID-19 related to the proper utilization of personal protective equipment (PPE) for 1 of 4 resident (R213) reviewed for transmission based precautions (TBP). In addition, the facility failed to ensure isolation gowns were not reused for 1 of 4 residents (R311) reviewed for infection control practices. Further, the facility failed to ensure a catheter drainage bag was kept off the floor to prevent contamination for 1 of 3 residents (R5) who utilized indwelling urinary catheters. Current CDC guidance dated 2/10/21, directed health care workers who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. CMS COVID-19 Long Term Care Facility Guidance, dated 4/2/20, directed nursing homes to immediately ensure they were complying with all Centers for Medicare & Medicaid Services (CMS) and CDC guidance related to infection control which included the use of standard, contact and droplet precautions. R213's Detailed Summary dated 8/16/21, indicated R213 was readmitted to the facility on 7/30/21, and included diagnoses of Parkinson's disease, dementia, repeated falls, left scapula, multiple rib fractures, and a wedge compression fracture.	21390	Corrected	

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R213's admission Minimum Data Set (MDS) dated 7/30/21, indicated R213 had severe cognitive impairment, and required extensive assist with bed mobility, transfers, dressing, toileting, one assist with eating and personal hygiene. R213's MDS further indicated falls prior to admission, in the last 2-6 months prior to admission w/fracture and 2 falls since admission

R213's updated care plan dated 8/10/21, indicated R213 was at risk for falls, on the falling star program, and was to be in his doorway or at the nurses desk to maintain close observation. R213's care plan further indicated R213 was not vaccinated for COVID-19 and was at risk for COVID-19. R13's care plan directed was to wear a cloth face mask if tolerated when staff was providing care or within six feet for R213 or when R213 was outside of R213's room. R213's care plan directed Therapeutic Recreation would provide in room leisure activities.

R213's physician orders dated 8/10/21, indicated R213 was allowed out of his room during the 14 day observation period which began 7/30/31, and ended 8/13/21.

On 8/9/21, at 2:21 p.m. signage was observed on R213's door, which indicated R213 was on droplet and contact precautions, and required an isolation gown, mask, eye protection, and gloves before entering R213's room. R213 was not observed in room at that time.

On 8/9/21, at 5:10 p.m. R213 sat at the nurse's station on the Rapid Recovery unit., and R213's mask did not cover R213's nose or mouth but was down around R213's chin. Staff and residents were observed to walk by R213 less

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21390	Continued From page 5 than six from R213. R213 while R213 sat in the main pathway by the nurses desk. On 8/9/21, at 7:05 p.m. registered nurse (RN)-G stated R213 was on quarantine for 14 days because R213 was readmitted from the hospital and had not received the COVID 19 vaccine. RN-G stated before entering R213's room PPE needed was a gown, N95 mask, gloves, and eye protection. On 8/9/21, at 7:09 p.m. R213 sat outside of the threshold of his room and ate supper on the tray table. During supper meal, nursing assistant (NA)-F was observed to stand less than six feet from R213 outside of R213's doorway and assisted R213 with supper by handing R213 his fork. NA-F wore eye protection and a surgical mask; but did not wear a gown, gloves, or N95 respirator. RN-D approached NA-F and instructed NA-F to put an isolation gown and gloves on when working with R213. On 8/9/21, at 7:10 p.m. NA-F verified she should have donned an isolation gown and gloves while assisting R213 with supper. On 8/9/21, at 7:11 p.m. RN-D stated R213 was on a 14-day quarantine and droplet precautions because R213 was readmitted from the hospital and had not received the COVID-19 vaccine. RN-D stated staff should wear an isolation gown, gloves, eye protection, and a mask when working with residents on quarantine. RN-D verified she instructed NA-F to put on an isolation gown and gloves while supervising R213 during supper. On 8/10/21, at 8:36 a.m. NA-G sat with R213 outside of the threshold of R213's doorway while R213 ate breakfast in arm's reach of R213.	21390		

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21390	Continued From page 6 NA-G did not wear a gown, gloves or N95 mask. On 8/10/21, at 5:44 p.m. R213 sat at the nurses station on the Rapid Recovery unit, and R213's mask did not cover R213's nose or mouth but was down around R213's chin. On 8/11/21, at 12:17 p.m. R213 sat in his wheelchair in the threshold of his room and ate lunch while speech therapist (ST)-A sat next to him. ST-A wore a clear face shield, surgical mask, and gown. On 8/11/21, at 3:38 p.m. R213 sat at the Rapid Recovery unit nurses' station, and listened to country music, and wore a surgical mask around his mouth and nose. LPN-B only wore a surgical mask, and eye protection, and knelt next to R213 and sang to R213. On 8/12/21, at 8:41 a.m. R213 sat in his wheelchair outside the threshold of his doorway, wore a clear face shield without a mask. On 8/12/21, at 9:34 a.m. RN-E stated not all staff had been fit tested for N95 respirators and the facility tried to catch staff as they could. RN-E stated if staff were not N-95 fit tested, staff should not enter isolation rooms. RN-E stated she did not have a current plan to ensure staff were fit tested for use of an N95 respirator. On 8/12/21, at 9:44 a.m. NA-D and NA-E were observed to wear face shields, gowns, gloves, and surgical masks as they escorted R213 to his room from the Rapid Recovery nurses' station. They entered the room and closed the door. On 8/12/21, at 9:48 a.m. NA-D and NA-E exited R213's room and wore surgical masks and face	21390		

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21390	Continued From page 7 shields. On 8/12/21, at 9:50 a.m. NA-D stated she assisted R213 with a transfer into bed. NA-D stated she did not wear an N95 when she assisted R213 into bed and should have worn one. NA-D stated she had been fit tested for N95. Review of facility documentation however, indicated NA-D had not been N95 fit tested. On 8/12/21, at 9:59 a.m. NA-E stated she had assisted R213 into bed and verified she did not wear an N95 mask, and only wore a surgical mask when she assisted R213 into bed. NA-E stated she had not been fit tested to wear an N95 respirator. On 8/12/21, at 11:56 a.m. physical therapist (PT)-A was observed being fit tested for an N95 respirator in the education room. At 8/12/21, at 11:57 a.m. PT-A exited the education room and stated he was just fit tested for a N95 respirator and was informed about the testing that day. PT-A stated he had worked with residents in quarantine rooms, and prior to that had not been N95 fit tested. On 8/12/21, at 12:29 p.m. RN-E provided list of employees and indicated the ones who were not N95 fit tested. The facilities staff scheduled was reviewed and compared to the list of employees who were not N95 fit tested, revealed on the night shift for 8/9/21 and 8/11/21, none of the 12 staff who worked, had been fit tested for use of an N95 mask. On 8/12/21, at 2:29 p.m. DON stated it was the expectation staff who worked with residents on quarantine to be N95 fit tested and wear an N95 respirator. The DON further stated if staff were	21390		

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not fit tested for an N95 respirator or had medical exclusions to wear an N95 respirator, staff should not enter any rooms on quarantine.

On 8/13/21, at 11:44 a.m. RN-F stated R213 was on Falling Stars due to R213's impulsiveness, poor judgement, and subsequent falls and required to be in line of sight. RN-F stated R213 was on quarantine because R213 was a readmission, was unvaccinated and required a 14-day quarantine. RN-F stated R213 was allowed out of his room because R213 needed to be in line of sight of staff because R213 would get out of his wheelchair and attempt to stand. RN-F stated there were no designated staff assigned to R213 for one on ones, and staff would just tag team. RN-F stated sometimes RN-F would sit at the nurse's station and other times R213 sat in his doorway so staff could see R213.

The facility policy Management of Suspected or Confirmed Corona Virus (COVID-19) revised 8/13/21, directed to quarantine all admitted and readmitted residents regardless of diagnosis, fall risk, and/or cognition in their rooms for 14 days unless they are fully vaccinated. The policy was updated to also include, the facility would also be doing fit testing for employees on the use of N95 respirators upon hire if that employee will be in direct contact with residents or will have the need to enter a quarantine room.

R311's Profile Face Sheet indicated R311 was admitted on 8/5/21.

R311's Resident Diagnosis List printed 8/13/21, indicated R311's diagnoses included hemiplegia (paralysis of one side of the body) of left nondominant side, dysphagia (difficulty

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swallowing food and liquids), diabetes mellitus type II, depression, morbid obesity, and ateriovenous malformation of cerebral vessels (an abnormal connection of blood vessels in the brain or spine).

R311's care plan initiated on 8/5/21, directed R311 would remain on a 14 day room restriction upon admission or readmission to the facility during the pandemic.

On 8/9/21, at 6:27 p.m. the dinner tray service to rooms was observed on the Pinecone Lodge unit. Nursing assistant (NA)-A was observed donning personal protective equipment (PPE) prior to bringing R311 a meal tray. Registered nurse (RN)-B could be heard talking to NA-A from inside R311's room. RN-B stated she was going to hang her isolation gown in the room to use the next time she needed to enter R311's room. When RN-B exited the room she was interviewed, RN-B verified she was unsure if re-using an isolation gown was acceptable practice but had been in/out of the room at least four times already. RN-B verified she was re-using her isolation gown, she verified the facility did not have a shortage on isolation gowns.

On 8/9/21, at 6:36 p.m. RN-B verified it was not acceptable practice to hang isolation gowns in the quarantine room and continue to use them.

On 8/13/21, at 11:34 a.m. the director of nursing (DON) verified it was not acceptable practice for staff to re-use isolation gowns.

The facility policy titled Personal Protective Equipment for Resident with Confirmed or Suspected COVID-19 directed staff to discard the

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21390	Continued From page 10 isolation gown in a waste container or hamper after removing. R5's Detailed Summary Sheet printed 8/12/21, indicated R5's diagnoses included a history of urinary tract infections, severe sepsis with septic shock (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues), acute kidney failure, chronic kidney disease, diabetes, and retention of urine. R5's quarterly Minimum Data Set (MDS) assessment dated 5/5/21, indicated R5 had a severe cognitive impairment, had an indwelling catheter, had a urinary tract infection (UTI) in the past 30 days and sepsis. R5 required extensive assist with toileting cares. R5's physician orders dated 8/12/21, included: -Change specified catheter monthly for retention of urine -Do not irrigate Foley catheter, change as needed for leaking or decreased urinary output using similar sized catheter. Change catheter and tubing prior to obtaining a urinalysis/urine culture sample. May attach leg bag when out of bed then re-attach to straight drainage when in bed. Flush only when instructed by urology, then use a regular flush when indicated. -Foley catheter cares every shift R5's care plan initiated 6/9/21, identified R5's risk of infections related to the catheter, and directed catheter cares and changes, and for catheter bag to be hung below level of bladder at all times, but lacked directives to ensure catheter drainage bag was kept off the floor.	21390		

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21390	Continued From page 11 R5's nursing assistant (NA) worksheet/communication dated 8/11/21, directed NA's to provide catheter cares every shift and as needed, but lacked directives for positioning of catheter and to ensure R5's catheter drainage bag was kept off the floor. R5's Interdisciplinary Notes dated 8/11/21, for care conference on 8/10/21, indicated R5 had been hospitalized from 6/6/21, through 6/9/21, with a UTI and sepsis. On 8/9/21, at 3:12 p.m. R5 was observed lying in bed with his catheter drainage bag sitting on the privacy bag which was on the floor. On 8/12/21, at 8:20 a.m. R5 was observed to be lying in bed, with his catheter drainage bag hanging from the bottom right side of his bed, in a cloth privacy bag, touching the floor. On 8/12/21, at 8:34 a.m. NA-C entered R5's room to do morning cares, including catheter cares. NA-C verified R5's catheter drainage bag and cloth privacy bag were sitting on the floor and should have been hung to keep off the floor. NA-C stated the catheter privacy bag was wet and needed to be changed. NA-C washed up R5, provided catheter cares using proper infection control practices, and dressed R5. NA-C stated it appeared that R5's catheter was getting clogged, as it had some sediment in the tubing, so would tell the nurse. NA-C transferred R5 into the wheelchair and hung the catheter drainage bag under the wheelchair, off the floor. NA-C went to inform licensed practical nurse (LPN)-A that R5's catheter drainage bag had been on the floor and to get a privacy bag to cover R5's catheter drainage bag.	21390		

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21390	Continued From page 12 On 8/12/21, at 9:20 a.m. LPN-A changed R5's catheter drainage bag, placed it in a clean privacy bag, and hung it under R5's wheelchair. LPN-A verified R5's catheter tubing had sediment in it and stated she did not like that, so would talk to R5's case manager. LPN-A verified the catheter drainage bags, even when in a privacy bag, should not be hanging so it touched the floor due to risk of infection. On 8/12/21, at 10:27 am. registered nurse (RN)-C verified catheter drainage bag and privacy bag should not be touching the floor. On 8/12/21, at 2:44 p.m. director of nursing (DON) verified catheter drainage bags should be kept off the floor to prevent cross-contamination and risk of infection. The facility policy and procedure for Urinary Catheter Care reviewed 6/21, lacked directives to ensure the catheter drainage bag and tubing were hung so they were not touching the floor or contaminated surface. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff are following all infection control practices. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		

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21426	Continued From page 13	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (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. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an employee's second step Tuberculin skin test (TST) (a skin test used to check for tuberculosis infection) was completed timely for 1 of 5 employees reviewed for TST. Findings include: Trained medication aide (TMA)-A's Baseline Tuberculin (TB) Screening form indicated TMA-A	21426	Corrected	9/27/21

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21426	Continued From page 14 received her first step TST on 3/26/18, and TMA-A received the second step TST on 6/22/18, three months after receiving the first step TST. The Center for Disease Control TB Screening and Testing of Health Care Personnel updated 3/8/21, for Baseline Testing: Two-Step Test directed: Step 1 Administer first TST following proper protocol Review result Positive - consider TB infected, no second TST needed; evaluate for TB disease. Negative - a second TST is needed. Retest in 1 to 3 weeks after first TST result is read. Document result Step 2 Administer second TST 1 to 3 weeks after first test Review results Positive - consider TB infected and evaluate for TB disease. Negative - consider person not infected. Document result On 8/13/21, at 3:11 p.m. registered nurse (RN)-E verified TMA-A's 2nd step TST was given three months after first step TST was administered. RN-E stated the second step TST was given be given 2 weeks after the first step TST. RN-E stated TMA-A's TST series should have been started over. On 8/13/21, at 3:39 p.m. the director of nursing (DON) stated she would refer to RN-E's timeline for administering TST's as RN-E was responsible for tracking TST's. The facility policy Tuberculosis	21426		

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(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) COMPLETE DATE
21426	Continued From page 15 Screening-Employees revised 6/21, directed second step TST can have a time frame suggested of one to three weeks, but not greater than 365 days. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure Tuberculosis screenings and testing for staff and residents are completed according to the Center for Disease Control recommendations. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245330	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**08/12/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/12/2021. At the time of this survey, Country Manor Health care & Rehab Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Country Manor Health & Retirement is a one-story building with no basement and is fully sprinklered. The building was constructed at eight 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 was 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 II(111) construction. Because the original building and the additions meet the construction types allowed for existing	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 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 165 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		