DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL **PART**

DICARE/MEDICALD CERTIFICATION AND TRANSMITTAL	ID: IV6L
Γ I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	Facility ID: 00627

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245330 3. NAME AND ADDRESS OF FACILITY (L3) COUNTRY MANOR HEALTH				LTH & RE	1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID N (L2) 943188800	Ю.	(L4) 520 FIRST S (L5) SARTELL, 1		THEAST	(L6) 56377	3. Terminati 5. Validation	
5. EFFECTIVE DATE CHANGE OF C	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site V 8. Full Surve	isit 9. Other ey After Complaint
6. DATE OF SURVEY 10/06 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/ 2021 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR 06/30	ENDING DATE: (L35)
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14. LTC CERTIFIED BED BREAKDO' 18 SNF 18/19 SNF	WN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15	i)
165 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENO	CY APPROVAL	Date:
Teresa Ament, Unit Supervisor		1	0/15/2021	(L19)	Joanne Simon, Enforcement S	Specialist	10/15/2021 (L20)
	RT II - TO BE			` /	Joanne Simon, Enforcement S		(L20)
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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



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



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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	_	-	_	-	AND TRANSMITTAL TE SURVEY AGENCY		ID: IV6L Facility ID: 00627
1. MEDICARE/MEDICAID PROVID (L1) 245330 2.STATE VENDOR OR MEDICAID (L2) 943188800	DER NO.	3. NAME AND AD (L3) COUNTRY I (L4) 520 FIRST S (L5) SARTELL, I	DDRESS OF FACE	CILITY ALTH & RI		4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	ON: 2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) 6. DATE OF SURVEY 08/18 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 165 (L37) (L38)	6/2021 (L34) — (L10) DN 165 (L18) 165 (L17) OWN 19 SNF (L39)	X B. Not in Com Requirements	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP T IS CERTIFIED nee With equirements to Based On: cceptable POC appliance with Progrand/or Applied V IID (L43)	09 ESRD 10 NF 11 ICF/IID 12 RHC AS:	02	6. Scope of 2	DING DATE: (L35) ments: Services Limit Director som Size
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PA	ART II - TO BE (COMPLETED E	BY HCFA RE	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	
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28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



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

PRINTED: 10/04/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245330	B. WING			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	00/	16/2021
COUNTR	Y MANOR HEALTH 8	REHAB CTR		520 FIRST STREET NORTHEAST SARTELL, MN 56377		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	compliance with Ap Preparedness Requested during a survey. The facility The facility is enroll signature is not requested page of the CMS-2s correction is require acknowledge receip INITIAL COMMENTO On 8/9/21, through recertification survefacility. A complaint conducted. Your faccompliance with the	a 8/16/21, a survey for pendix Z, Emergency uirements, §483.73(b)(6) was standard recertification was IN compliance. ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents. TS 8/16/21, a standard ey was conducted at your investigation was also cility was found to be NOT in e requirements of 42 CFR 483, ments for Long Term Care	F 0	00		
	SUBSTANTIATED related to the defici complaints were for H5330056 (MN697 (MN66857) howeved due to actions implesurvey:	plaint was found to be H5330055C (MN67118), ency at F880. The following und to be SUBSTANTIATED 46), and H5330054C er NO deficiencies were cited emented by the facility prior to				
LADODATOD	UNSUBSTANTIATE H5330046C (MN52 H5330047C (MN53 H5330048C (MN53	532) 249)	NATI IDE	TITLE		(X6) DATE

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

TITLE

Electronically Signed

09/17/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245330		` ′	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED C	
		B. WING _		08/16/2021		
	PROVIDER OR SUPPLIER Y MANOR HEALTH 8	REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	.D BE	(X5) COMPLETION DATE
F 000	as your allegation of Departments accept enrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an onsite revisit of you validate that substate regulations has been	2205) 2332) 2608) 2656) 2656) 26 correction (POC) will serve of compliance upon the example of the CMS-2567 ic submission of the POC will tion of compliance. 20 cacceptable electronic POC, an or facility may be conducted to ential compliance with the	F 00			
	(IJ) at F880 when the newly readmitted unwas appropriately of failed to ensure proceeding equipment (PPE) for ensure staff working use N95's as appropriated and provided The IJ began on 8/17/2 Care Plan Timing at CFR(s): 483.21(b) (S483.21(b) Compressible S483.21(b) (2) A combe-	the facility filed to ensure a invaccinated resident, R213, quarantined. The facility also oper use of personal protective or staff including failure to g with residents in quarantine opriate when they had been fit in the appropriate supplies. 12/21, and the immediacy was 1. Ind Revision (2)(i)-(iii) The densive Care Plans in the properties of the appropriate supplies. (2)(i)-(iii)	F 65	7		9/27/21

AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		245330	B. WING _		C 08/16/2021		
	ROVIDER OR SUPPLIER	REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CO 520 FIRST STREET NORTHEAST SARTELL, MN 56377	· •	10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	includes but is not (A) The attending p (B) A registered nursesident. (C) A nurse aide w resident. (D) A member of for (E) To the extent p the resident and the resident and the resident and their resident runot practicable for resident's care pland (F) Other appropriate disciplines as deteor as requested by (iii) Reviewed and runder team after each as comprehensive an assessments. This REQUIREME by: Based on interview facility failed to ensprovided in writing representatives (Rulans. Findings include: R87's Detailed Sur 8/13/21, indicated sequela of nontrau (bleeding inside the	interdisciplinary team, that limited to ohysician. rse with responsibility for the lith responsibility for the lith responsibility for the lood and nutrition services staff. It racticable, the participation of e resident's representative(s). It is to encluded in a resident's representative is determined the development of the lith representative is determined the development of the lith resident. In the staff or professionals in remined by the resident's needs the resident. Evised by the interdisciplinary sessment, including both the	F 65	F657 1. Corrective action for residentified in deficiency: Re educated baseline care pimmediately with RN CM; baplan completed and in compon 7/09/2021 however was roffered/provided to identified timely. RN CM spoke with representative reviewed care offered. R96 baseline care pcompleted within regulatory.	plan policy aseline care diance for R87 not I resident esident e plan and		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
245330		245330	B. WING _		C 08/16/2021	
NAME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		
				520 FIRST STREET NORTHEAST		
COUNTRY MANOR HEALTH & REHAB CTR		& REHAB CTR		SARTELL, MN 56377		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From pa	age 3	F 65	7		
	(build up of fats an	I atherosclerotic heart disease d cholesterol in and on the g arteries to narrow and /).		Facility will identify other with potential to be affected:		
	7/15/21, identified cognition, and was activities of daily liv dependent on tube R87's care plan sta	finimum Data Set (MDS) dated R87 had severely impaired totally dependent for all ving (ADL). In addition R87 was e feeding for nutrition. arted on 7/16/21, addressed aired elements for effective and are.		The facility will identify and a resident sadmitted to the facility weeks starting 9/10/21 thru to Beginning on 9/25 4 new partial be audited weekly for on ensure distribution of baseling to patient/representative. The be conducted on a routine becontinued compliance. Same expanded as deemed necessions.	acility for 2 09/24/2021. atient records e month to ne care plan e audits will asis to ensure ple will be	
	and FM-B were into stated they could in conference or beint baseline care plan R87's admission. F asking him anythin preferences.	28 a.m. family member (FM)-A erviewed. FM-A and FM-B not recall attending any care g offered a copy of the in the first couple of days after FM-A could not recall any staff g about R87's daily on 8/13/21, at 9:08 a.m. the ervices (SW)-A stated there		3. Measures and systemic made to ensure deficient pra reoccur: Mandatory re-education of b plan policy provided to response Education included intent of plan, policy and expectations Competency completed. 4 n records will be audited week month to ensure compliance	paseline care possible staff. baseline care s. ew patient	
	should have been care conference an notes. SW-A review could not find any rand baseline care offer residents and copy of the baselin and/or resident repropries of anything. During an interview on 8/13/21, at 9:58	a progress note about the initial nd care plan in R87's progress wed the progress notes but notes on the care conference plan. SW-A stated they do not resident representatives a see care plan but the resident presentative could ask for		distribution of baseline care patient/representative. On-g mentoring will be conducted necessary. 4. The facilities plan to mo performance, measure effect integrate into the quality ass program: The facility will assure continuous compliance by auditing 4 nerecords weekly for one mondistribution of baseline care	plan to oing staff as deemed nitor ctiveness and urance nued w patient th to ensure	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		245330	B. WING			C 16/2021	
	PROVIDER OR SUPPLIER	P DELIAD CTD		STREET ADDRESS, CITY, STATE, ZIP C 520 FIRST STREET NORTHEAST		10/2021	
COUNTRY MANOR HEALTH & REHAB CTR			SARTELL, MN 56377				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	Continued From pa	age 4	F 65	7			
	R87 and/or their re	presentative.		patient/representative. If no practice is observed immed education and correction wi	iate re Il be done at		
	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			time of audit. Thereafter audits will be conducted on a routine basis and monitored through the Quality Assura Improvement Process. If quality issuare identified, facility policies and procedures will be reviewed and appropriate interventions will be implemented. DON and nursing leadership will be responsible for			
	R96's quarterly MD R96 was moderate			correction, monitoring, and DON responsible for continucempliance. Date of Correction 9-27-202	ued		
		R96 on 8/10/21, at 10:53 a.m. uld not recall receiving any					
	a.m. SW-A reviewed could not find docu conference was co	with SW-A on 8/13/21, at 9:01 ed R96's progress notes but mentation that the care mpleted and that a copy of the was provided to the resident representative.					
		rector of nursing (DON) stated ves the baseline care plan to eir families.					
	expectation that sta	OON verified it was her aff would enter a progress note base line care plan was ent and/or their representative					

Facility ID: 00627

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING		COMPLETED	
		245330	B. WING			C / 16/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 520 FIRST STREET NORTHEAST SARTELL, MN 56377		716/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPORT DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657		aseline Care Plan review date	F 6	57		
F 880 SS=K	plan within 48 hours baseline care plan i that is provided to tl in language that can directed staff would	n & Control	F 8	80		9/27/21
	infection prevention designed to provide comfortable enviror	tablish and maintain an and control program a safe, sanitary and ament and to help prevent the cansmission of communicable				
	program. The facility must es	n prevention and control tablish an infection prevention n (IPCP) that must include, at owing elements:				
	reporting, investigate and communicable staff, volunteers, vis providing services arrangement based conducted according accepted national standard and contact accepted standard accepted standa	I upon the facility assessment ng to §483.70(e) and following standards;				
	§483.80(a)(2) Writte	en standards, policies, and				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245330	B. WING				0	
NAME OF F	PROVIDER OR SUPPLIER	243330	D. WINO		TREET ADDRESS, CITY, STATE, ZIP CODE	08/	16/2021	
COUNTR	Y MANOR HEALTH &	REHAB CTR			20 FIRST STREET NORTHEAST SARTELL, MN 56377			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE	
F 880	but are not limited to (i) A system of surve possible communication infections before the persons in the facility. When and to whose communicable diserported; (iii) Standard and the tobe followed to provide (iii) Standard and the tresident; including the tresident; including the tresident; including the tresident (iii) A requirement to the least restrictive postic recumstances. (v) The circumstances. (v) The circumstances. (v) The circumstances. (vi) The circumstance (vi) The hand hygier by staff involved in \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must had transport linens so infection.	program, which must include, oc eillance designed to identify able diseases or ey can spread to other ity; som possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a cout not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility eyees with a communicable skin lesions from direct to the disease; and the procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the taken by the facility.	F	380				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, a solebino				
		245330	B. WING		1	16/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
COUNTE	RY MANOR HEALTH &	REHAB CTR		520 FIRST STREET NORTHEAST			
	1			SARTELL, MN 56377			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 880	IPCP and update the This REQUIREMENT by: Based on observator review, the facility for (R213) who was reason for COVID-19. The immediate jeopardy for transmission of facility failed to follow Control (CDC) guid minimize the transmithe proper utilization equipment (PPE) for reviewed for transmical (TBP). In addition, isolation gowns were residents (R311) repractices. Further, to catheter drainage by prevent contaminator who utilized indwell. The IJ began on 7/3 re-admitted from the toquarantine R213 for COVID-19. The transmission-based necessary personal including N95 respin administrator and denotified of the IJ on was removed on 8/10 noncompliance remseverity level of Ep	ge 7 leir program, as necessary. NT is not met as evidenced lion, interview, and document ailed to quarantine a resident admitted and not vaccinated se practices resulted in an (IJ) due to the increased risk COVID-19. Further, the live the Centers for Disease elines to prevent and/or mission of COVID-19 related to not personal protective for 1 of 4 resident (R213) mission based precautions the facility failed to ensure re not reused for 1 of 4 viewed for infection control the facility failed to ensure a lag was kept off the floor to lion for 1 of 3 residents (R5) ing urinary catheters. 30/21, when R213 was the hospital and the facility failed who had not been vaccinated a facility failed to implement a precautions (TBP) utilizing all a protective equipment (PPE) rators, for R213. The facility irector of nursing (DON) were 8/12/21, at 4:50 p.m. The IJ 13/21, at 5:09 p.m. but mained at the lower scope and lattern, no actual harm with man minimal harm that is not	F8	Preparation, submission and implementation of this plan of condoes not constitute an admission agreement with the facts and condin the statement of deficiencies. Tacility has appealed the alleged deficiency F880. This plan of comprepared and executed as a mean continuously promote and improve of care and compliance with all apstate and federal regulatory requirand constitutes the facility som In response to the stated citation Country Manor Health Care and FCenter has taken the following activated in deficiency: On 8/12/21 resident was immediated brought to his room and 1:1 superwas provided until he went to bed night. It is noted that resident slee and has not had any falls during the nighttime hours. All staff entering room wore appropriate PPE includication gown, eye protection, gland N95 respirator). Quarantine (contact/droplet) were removed on 8/13/21 r/t being in the facility for Any staff that had the potential to quarantine rooms and had not yet tested were fit tested during their starting the evening of 8/12/21. The facility has changed its Mana of Suspected or Confirmed Coron	of our clusions The rection is as to equality plicable ements pliance. F880 Rehabitions: tely vision for the ps well ne y the ding oves 14 days. enter been fit 1st shift gement		

/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245330	B. WING				C 16/2021
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2021
					520 FIRST STREET NORTHEAST		
COUNTR	Y MANOR HEALTH	& REHAB CTR			SARTELL, MN 56377		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 880	Continued From p	age 8	F 8	380			
		ance dated 2/10/21, directed			(COVID-19) policy to include the fo	llowing	
		rs who enter the room of a			Isolate all admitted and readmitted		
		cted or confirmed SARS-CoV-2			residents, regardless of diagnosis,		
		there to Standard Precautions			risk, and/or cognition, in their room		
		I Institute for Occupational			days unless the resident has had	101 11	
		(NIOSH) approved N95 or			COVID-19 in the past 90 days and	or thev	
		er-level respirator, gown,			are fully vaccinated. Droplet and C		
	gloves, and eye pr				precautions will be utilized for 14 d		
	g.с.сс, са сус р.				from admission or readmission for		
	CMS COVID-19 L	ong Term Care Facility			circumstances.		
		/2/20, directed nursing homes			The facility will also be doing fit tes	ting for	
		sure they were complying with			employees on the use of N95 resp		
		dicare & Medicaid Services			upon hire if that employee will be in		
	(CMS) and CDC g	uidance related to infection			contact with quarantined residents		
		ided the use of standard,			have the need to enter an isolation		
	contact and drople				(i.e., nursing, therapy, social service activities, housekeeping).	es,	
	R213's Detailed S	ummary dated 8/16/21,					
		is readmitted to the facility on			Staff working on the afternoon of		
	7/30/21, and include	ded diagnoses of Parkinson's			8/12/2021 were educated on chang	ges in	
	disease, dementia	, repeated falls, left scapula,			policy immediately and all other sta	aff were	
	multiple rib fractur	es, and a wedge compression			educated prior to the start of their r	next	
	fracture.				shift.		
					9/15/2021 Additional education wit	h	
		Minimum Data Set (MDS)			competency was implemented.		
		icated R213 had severe					
		ent, and required extensive			Deficiencies, Plan of Correction (P	, .	
		bility, transfers, dressing,			Directed Plan of Correction (DPOC	;),	
		st with eating and personal			RCA, PIP and Infection Control		
		IDS further indicated falls prior			consultant⊡s credentials were revi		
		e last 2-6 months prior to			with Governing Board on 09/16/20		
	admission w/fractu	ure and 2 falls since admission			Meeting held with IC consultant, V		
					CC/Rehab, DON, Directors of Clini		
		are plan dated 8/10/21,			Rehab, Clinical Planning/ICP and I		
		as at risk for falls, on the falling			Quality reviewed 2567, POC,DPO		
		was to be in his doorway or at			RCA. Facility has fulltime ICP on s		
		maintain close observation.			and is involved in daily operations.		
		urther indicated R213 was not			Medical Director has been updated	ı on	
	Naccinated for ()()	VIII-TU AND WAS AT TICK FOR			deficiencies and all measures		I

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245330	B. WING			C 16/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				520 FIRST STREET NORTHEAST		
COUNTR	Y MANOR HEALTH	& REHAB CTR		SARTELL, MN 56377		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880 Continued From page 9		age 9	F 88	0		
	a cloth face mask providing care or w	care plan directed was to wear if tolerated when staff was within six feet for R213 or when of R213's room. R213's care		implemented to ensure regulate compliance.	ory	
	R213 was outside of R213's room. R213's care plan directed Therapeutic Recreation would provide in room leisure activities.			 Facility will identify other re with the potential to be affected The facility will identify other re- 	: sidents	
	R213 was allowed	orders dated 8/10/21, indicated out of his room during the 14 eriod which began 7/30/31, and	10/21, indicated who are on admission/r		tions or 9 infection: ure the	
	R213's door, which droplet and contact	p.m. signage was observed on indicated R213 was on it precautions, and required an		This audit will also include PPE audits that will audit staff for us respirators when entering these	and N95 e of N95	
		isk, eye protection, and gloves 113's room. R213 was not at that time.		(quarantine rooms) The audits will include if these seen fit tested. Audits will be conducted by nur		
	station on the Rap mask did not cove	p.m. R213 sat at the nurse's id Recovery unit., and R213's r R213's nose or mouth but		leadership staff on all shifts dai week. Sample will be expanded deemed necessary.	ly for one d as	
	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.			Auditing to verify the placemen new admission and resident loo to ensure transmission based p (TBP) are appropriately implem when cohorting residents for or	cation daily precautions pented	
	stated R213 was obecause R213 was	p.m. registered nurse (RN)-G on quarantine for 14 days s readmitted from the hospital		The facility will decrease these compliance for TBP are achiev	audits as ed.	
	RN-G stated before	red the COVID 19 vaccine. e entering R213's room PPE rn, N95 mask, gloves, and eye		 Measures and systemic ch made to ensure deficient practi recur: Mandatory education has been to all staff starting 8/12/2021 ar 	ce will not provided	
	threshold of his root table. During supp	p.m. R213 sat outside of the om and ate supper on the tray per meal, nursing assistant yed to stand less than six feet		continue to be done upon hire. education will include the afore policy changes. Additional educompetency started 9/15/2021.	This mentioned cation with	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY PLETED
						C
		245330	B. WING		•	16/2021
NAME OF F	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
COUNTE	RY MANOR HEALTH	P DEUAD CTD		520 FIRST STREET NORTHEAST		
COUNTR	T WANOR HEALTH	& REHAD CIK		SARTELL, MN 56377		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From p	page 10	F 8	80		
F 880	from R213 outside assisted R213 wit fork. NA-F wore emask; but did not respirator. RN-D instructed NA-F to gloves on when wore donned an it assisting R213 with a 14-day quaranti because R213 was and had not recei RN-D stated staff gloves, eye protect with residents on instructed NA-F to gloves while super On 8/10/21, at 8:3 outside of the thre R213 ate breakfa NA-G did not weat on 8/10/21, at 5:4 station on the Ray mask did not cover was down around On 8/11/21, at 12	e of R213's doorway and th supper by handing R213 his eye protection and a surgical wear a gown, gloves, or N95 approached NA-F and to put an isolation gown and working with R213. In p.m. NA-F verified she should solation gown and gloves while th supper. In p.m. RN-D stated R213 was on the and droplet precautions as readmitted from the hospital wed the COVID-19 vaccine. Should wear an isolation gown, action, and a mask when working quarantine. RN-D verified she to put on an isolation gown and ervising R213 during supper. In a gown, gloves or N95 mask. In a gown, gloves or N95 mask. In a gown, gloves or mouth but R213's er R213's nose or mouth but R213's chin.	F8	testing and education will also completed upon hire for app. Audits will be conducted by leadership staff on all shifts week. After that, audits will be on a routine basis to ensure compliance. Auditing to verify the placement admission and resident to ensure transmission base (TBP) are appropriately implement will be compliance for TBP are ach compliance for TBP are ach on-going staff mentoring will conducted as necessary. A revised and implemented to continued compliance. 4) The facilities plan to motoperformance, measure effect integrate into quality assurated Audits will be conducted by leadership staff on all shifts week If non complaint practice observed immediate releductor correction will be done at tin After that audits will be concroutine basis to ensure controutine basis to ensure controutine to ensure transmission based.	oropriate staff. Inursing Idaily for one Idaily for	
	wheelchair in the lunch while speed him. ST-A wore a mask, and gown.	threshold of his room and ate the therapist (ST)-A sat next to clear face shield, surgical 88 p.m. R213 sat at the Rapid		(TBP) are appropriately imp when cohorting residents fo The facility will decrease the compliance for TBP are ach All audits conducted will be through the Quality Assuran	r one month. ese audits as ieved. monitored	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED	
		245330	B. WING		C 08/16/2021	
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F 880 Continued From		age 11	F 88	0		
	country music, and his mouth and nos mask, and eye pro and sang to R213.	es' station, and listened to I wore a surgical mask around e. LPN-B only wore a surgical tection, and knelt next to R213		noncompliant practice is observe immediate re education and corre be done at time of audit. If issues identified, facilities policies and procedures will be reviewed and appropriate interventions will be implemented. DON and Infection	ection will	
	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.			Preventionist are responsible for correction, monitoring, effectivene implementing interventions.	ess and	
	had been fit tested facility tried to catc stated if staff were not enter isolation	4 a.m. RN-E stated not all staff for N95 respirators and the h staff as they could. RN-E not N-95 fit tested, staff should rooms. RN-E stated she did plan to ensure staff were fit n N95 respirator.		F880 1) Corrective action for resident identified in deficiency: The identified residents urinary dibags were immediately removed	rainage	
	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.			floor and hung up off of the floor a below level of the bladder. CNAs floor nurses were re-educated an counseled regarding urinary drain care and placement and express understanding of Country Manor Catheter Care Policy.	and d nage bag ed	
		B a.m. NA-D and NA-E exited wore surgical masks and face		 Facility will identify other resi with the potential to be affected: The facility will identify all residen have a urinary catheter. Audits w 	ts who	
	assisted R213 with stated she did not assisted R213 into one. NA-D stated	a.m. NA-D stated she a transfer into bed. NA-D wear an N95 when she bed and should have worn she had been fit tested for cility documentation however,		conducted by nursing leadership all shifts daily for one week for co drainage bag placement. Sample expanded as deemed necessary 3) Measures and systemic chan	staff on rrect e will be	
	indicated NA-D had On 8/12/21, at 9:59 assisted R213 into	d not been N95 fit tested. a.m. NA-E stated she had bed and verified she did not and only wore a surgical		made to ensure deficient practice recur: Mandatory re-education will be compared by all nursing staff and will include re-education on the Catheter Car	will not ompleted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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COUNTR	Y MANOR HEALTH	& REHAB CTR					
				•	SARTELL, MN 56377		
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F 880			F 8	380			
		ssisted R213 into bed. NA-E t been fit tested to wear an N95			and placement of drainage bags. Audits will be conducted by nursing leadership staff on all shifts daily fo week. After that audits will be conducted by the co	r one	
	(PT)-A was observes respirator in the ed	56 a.m. physical therapist ved being fit tested for an N95 ducation room. At 8/12/21, at exited the education room and			on a routine basis to ensure continucompliance. On-going staff mentor be conducted as deemed necessar 4) The facilities plan to monitor	ued ng will	
	and was informed PT-A stated he ha	tit tested for a N95 respirator about the testing that day. Id worked with residents in and prior to that had not been			performance, measure effectivenes integrate into the quality assurance program: The facility will assure continued		
	N95 fit tested.	·			compliance through audits complet nursing leadership staff on all shifts	daily	
	employees and in	29 p.m. RN-E provided list of dicated the ones who were not			for one week, then weekly audits for month. If noncompliant practice is		
	reviewed and com	e facilities staff scheduled was pared to the list of employees			observe immediate re education ar correction will be done at time of au	ıdit.	
		if it tested, revealed on the night d 8/11/21, none of the 12 staff			The audits will be conducted on a r basis and monitored through the Q		
		been fit tested for use of an N95			Improvement Process. If quality issues are identified, facili	-	
		O BON ALL L'I II			policies and procedures will be revi	ewed	
	expectation staff v	9 p.m. DON stated it was the who worked with residents on			and appropriate interventions will b implemented. DON and Infection	е	
		N95 fit tested and wear an N95 ON further stated if staff were			Preventionist are responsible for correction, monitoring effectiveness	s and	
	not fit tested for a	n N95 respirator or had medical r an N95 respirator, staff should			implementing interventions. Date of correction 9/27/21		
	not enter any roor						
	Om 0/40/04 -+ 44	44 a m DN C at-t 1 D040			F880		
		44 a.m. RN-F stated R213 was			Corrective action for resident		
		ue to R213's impulsiveness,			identified in deficiency:	-1	
		and subsequent falls and			Upon hearing of concern of potentia		
		ne of sight. RN-F stated R213			reuse of an isolation gown, nursing		
		e because R213 was a			leadership immediately re-educated		
		unvaccinated and required a			counseled the RN in question regard		
		e. RN-F stated R213 was			the proper use of PPE and not reus	sing	
	allowed out of his	room because R213 needed to			isolation gowns. RN verbalized		

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			SARTELL, MN 56377			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 880 Continued From p	page 13	F8	880			
be in line of sight out of his wheelch stated there were R213 for one on of team. RN-F states the nurse's station his doorway so stated the nurse's state implemented corrupted Management Corona Virus (CC quarantine all addregardless of diagonates in their rooms for vaccinated. The include, the facilit for employees on hire if that employ residents or will have quarantine room services, activities 8/13/21, were educted Manager Corona Virus (CC acknowledgment memo on the Reruprior to their schestaff (i.e. nursing, activities, housek enter quarantine in prior to entering of managers would appropriate employed communicate to to location of fit testi	of staff because R213 would get hair and attempt to stand. RN-F no designated staff assigned to ones, and staff would just tag at sometimes RN-F would sit at an and other times R213 sat in aff could see R213. Stice was corrected on 8/13/21, the facility developed and ective action to include updating of Suspected or Confirmed OVID-19) policy to include: nitted and readmitted residents gnosis, fall risk, and/or cognition 14 days unless they are fully policy was updated to also y would also be doing fit testing the use of N95 respirators upon the use of N95 respirators upon the will be in direct contact with ave the need to enter a (i.e., nursing, therapy, social shousekeeping). Staff working ucated on the Removal Plan and ment of Suspected or Confirmed ovID-19) policy. Staff signed they read and understood the moval plan and policy changes duled shift. Any appropriate therapy, social services, eeping) that had the potential to room were fit tested 8/13/21, uarantine rooms. Department be responsible for identifying oyees that require fit testing will heir employees the time and ng. On 8/13/21, between 4:00 n. nine RNs, seven LPN's, 13	F 8	understanding of this protoco of previous education. 2) Facility will identify other with the potential to be affect The facility will identify other who are on quarantine for eigendmission/readmission precesuspected/confirmed COVIE Weekly PPE audits will be caudit staff for proper donning of PPE when entering/exiting residents rooms as well as publication disposal of PPE. The PPE arevised to include proper disposal in trash receptacles. Audits conducted by nursing leader all shifts daily for one week. be expanded as deemed near all shifts daily for one week. be expanded as deemed near and will include Complete policies and procedures proper disposal of PPE after Audits will be conducted by leadership staff on all shifts week. After that, audits will on a routine basis to ensure compliance. On-going staff mentoring will conducted as necessary. Reconducted necessary. Reconducted necessary.	residents ted: residents ther 14-day autions or 0-19 infection. onducted to g and doffing g these proper udit has been sposal of PPE will be rship staff on Sample will cessary. changes actice will not all staff will be COVID-19 s including ruse. nursing daily for one be conducted continued I be evised audit determine cor ctiveness and nce program:		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CO 520 FIRST STREET NORTHEAST SARTELL, MN 56377			
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F 880	one maintenance is dietary staff, and or interviewed and ve verified they were in the facility policy in Confirmed Corona 8/13/21, directed to readmitted residentisk, and/or cognition unless they are full updated to also incoming fit testing for respirators upon hidirect contact with to enter a quarantification of the fact admitted on 8/5/21 resident Dindicated R311's dinected R3	ousekeepers, six therapists, staff, nine activity staff, nine ne volunteer coordinator were rified the above education and N95 fit tested. Management of Suspected or Virus (COVID-19) revised of quarantine all admitted and its regardless of diagnosis, fall on in their rooms for 14 days y vaccinated. The policy was elude, the facility would also be employees on the use of N95 re if that employee will be in residents or will have the need ne room. Sheet indicated R311 was esheet indicated R311 was diagnosis List printed 8/13/21, agnoses included hemiplegia de of the body) of left dysphagia (difficulty ad liquids), diabetes mellitus, morbid obesity, and formation of cerebral vessels ection of blood vessels in the initiated on 8/5/21, directed on a 14 day room restriction readmission to the facility	F 880	week. If noncompliant observed immediate re educ correction will be done at tim The audits will be conducted basis and monitored through Assurance Process. If issue identified, facilities policies a procedures will be reviewed appropriate interventions will implemented. DON and Infe Preventionist are responsib correction, monitoring effect implementing interventions. Date of correction: 9/27/202	cation and ne of audit. If on a routine in the Quality es are and and I be ction le for iveness and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245330	B. WING				16/2021
	PROVIDER OR SUPPLIER RY MANOR HEALTH 8	REHAB CTR		520	REET ADDRESS, CITY, STATE, ZIP CODE D FIRST STREET NORTHEAST RTELL, MN 56377	1 001	10/2021
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F 880	(RN)-B could be he inside R311's room to hang her isolation next time she need When RN-B exited interviewed, RN-B re-using an isolatio practice but had be four times already. re-using her isolatic facility did not have gowns. On 8/9/21, at 6:36 pacceptable practice quarantine room ar On 8/13/21, at 11:3 (DON) verified it wastaff to re-use isolatic facility policy tirequipment for Resi Suspected COVID-isolation gown in a after removing. R5's Detailed Sumindicated R5's diagurinary tract infections shock (a potentially occurs when the bedamages its own tischronic kidney diseurine.	eal tray. Registered nurse eard talking to NA-A from . RN-B stated she was going n gown in the room to use the ed to enter R311's room. the room she was verified she was unsure if n gown was acceptable een in/out of the room at least RN-B verified she was on gown, she verified the a shortage on isolation o.m. RN-B verified it was not e to hang isolation gowns in the nd continue to use them. 4 a.m. the director of nursing as not acceptable practice for	F 8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
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F 880	Continued From pa	ge 16	F 8	80			
	catheter, had a urin	pairment, had an indwelling nary tract infection (UTI) in the epsis. R5 required extensive cares.					
	-Change specified of urine -Do not irrigate Fold for leaking or decresimilar sized cathet tubing prior to obtain sample. May attact re-attach to straight						
	of infections related catheter cares and bag to be hung belo	ated 6/9/21, identified R5's risk d to the catheter, and directed changes, and for catheter ow level of bladder at all times, es to ensure catheter drainage e floor.					
	NA's to provide cat needed, but lacked	nication dated 8/11/21, directed heter cares every shift and as directives for positioning of sure R5's catheter drainage					
	care conference on	ry Notes dated 8/11/21, for a 8/10/21, indicated R5 had rom 6/6/21, through 6/9/21, sis.					
		o.m. R5 was observed lying in er drainage bag sitting on the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED C	
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F 880	privacy bag which On 8/12/21, at 8:20 lying in bed, with h hanging from the b cloth privacy bag, 1 On 8/12/21, at 8:34 to do morning care NA-C verified R5's cloth privacy bag w should have been NA-C stated the ca and needed to be of R5, provided cathe infection control pr NA-C stated it app getting clogged, as tubing, so would te R5 into the wheele drainage bag unde NA-C went to infor (LPN)-A that R5's of been on the floor a cover R5's cathete On 8/12/21, at 9:20 catheter drainage I bag, and hung it ur verified R5's cathe and stated she did R5's case manage drainage bags, eve should not be hang to risk of infection.	was on the floor. O a.m. R5 was observed to be is catheter drainage bag nottom right side of his bed, in a couching the floor. A a.m. NA-C entered R5's room as, including catheter cares. catheter drainage bag and were sitting on the floor and hung to keep off the floor. Atheter privacy bag was wet changed. NA-C washed up ofter cares using proper actices, and dressed R5. The eared that R5's catheter was as it had some sediment in the catheter or the wheelchair, off the floor. The incensed practical nurse catheter drainage bag had and to get a privacy bag to	F 88			
		heter drainage bag and privacy				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING		` ´COMI	E SURVEY PLETED
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F 880	(DON) verified cath kept off the floor to and risk of infection. The facility policy a Catheter Care revieensure the catheter	p.m. director of nursing leter drainage bags should be prevent cross-contamination in the procedure for Urinary lewed 6/21, lacked directives to drainage bag and tubing levere not touching the floor or	F8	880			



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 <u>only a suggestion</u> 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

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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2 000	Initial Comments			2 000			
	****ATTENTION*****						
	NH LICENSING CORRECTION ORDER						
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, ction order has bee ey. If, upon reinspectiency or deficiencie ected, a fine for each be assessed in accfines promulgated bartment of Health.	n issued ction, it is s cited h violation ordance				
	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.						
	that may result from orders provided that the Department wit	hearing on any ass n non-compliance w at a written request i hin 15 days of recei ent for non-compliar	vith these s made to pt of a				
	was conducted at y the Minnesota Dep facility was found N State Licensure and orders are issued.	TS: 8/16/21, a licensing our facility by surve artment of Health (NOT in compliance volume the following correction you have rection you have	yors from MDH). Your vith the MN ection our				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 09/17/21

TITLE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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2 000	Continued From pa	ge 1	2 000			
	these orders and id be completed.	entify the date when they will				
	the State Licensing federal software. To assigned to Minnes Nursing Homes. The appears in the far let Tag." The state statisted in the "Summ column and replace the correction order the findings which a statute after the state as evidence by." For are the Suggested Time period for Correction or Correction order the Suggested Time period for Correction for Corrections are the Suggested Time period for Corrections and the Suggested Time period for Corrections are the Suggested Tim	participate in the electronic				
	receipt of State lice the Minnesota Dep. Informational Bullet https://www.health. n/infobulletins/ib14 orders are delineate Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm	nsure orders consistent with artment of Health cin state.mn.us/facilities/regulatio _1.html The State licensing ed on the attached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.				
		N WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

Minnesota Department of Health

STATE FORM 6899 IV6L11 If continuation sheet 2 of 16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED					
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2 000	Continued From pa	ge 2	2 000								
	THIS WILL APPEA IS NO REQUIREM CORRECTION FO	R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF									
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident himmunization progratefined in part 465 procedures of resid the prevention and F. the development of the prevention of the prevention and F. the development of the prevention o	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of ect infection control, such as eptics, gloves, and	21390			9/27/21					
	current standards o	maintaining awareness of of practice in infection control. ent is not met as evidenced									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
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COUNTRY MANOR HEALTH & REHAB CTR 520 FIRST STREET NORTHEAST SARTELL, MN 56377												
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21390	Continued From page 3		21390									
	Based on observation review, the facility for (R213) who was refor COVID-19. Furthe Centers for Distoprevent and/or many covident (R213) review resident (R31) to ensure isolation of 4 residents (R31) control practices. Fensure a catheter of floor to prevent condition (R5) who utilized in Current CDC guidanealth care workers patient with suspect infection should add and use a National Safety and Health (equivalent or higher gloves, and eye processed of the condition	ion, interview, and document ailed to quarantine a resident admitted and not vaccinated her, the facility failed to follow ease Control (CDC) guidelines ninimize the transmission of to the proper utilization of equipment (PPE) for 1 of 4 viewed for transmission based In addition, the facility failed gowns were not reused for 1 1) reviewed for infection further, the facility failed to drainage bag was kept off the atamination for 1 of 3 residents dwelling urinary catheters. Ince dated 2/10/21, directed a who enter the room of a sted or confirmed SARS-CoV-2 here to Standard Precautions Institute for Occupational (NIOSH) approved N95 or relevel respirator, gown,		Corrected								
	indicated R213 was 7/30/21, and includ disease, dementia,	immary dated 8/16/21, sreadmitted to the facility on ed diagnoses of Parkinson's repeated falls, left scapula, es, and a wedge compression										

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		00627		B. WING		08/1	6/2021
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21390	Continued From pa	ge 4		21390			
	dated 7/30/21, indic cognitive impairmed assist with bed most toileting, one assist hygiene. R213's MI to admission, in the admission w/fracture R213's updated call indicated R213 was star program, and with the nurses desk to R213's care plan for vaccinated for COVCOVID-19. R13's care of a cloth face mask it providing care or with R213 was outside of the control o	Minimum Data Set (cated R213 had sevent, and required extendility, transfers, dress with eating and per DS further indicated e last 2-6 months price and 2 falls since are plan dated 8/10/2 at risk for falls, on was to be in his door maintain close observather indicated R21 /ID-19 and was at ricare plan directed we for tolerated when statistin six feet for R21 of R213's room. R2 apeutic Recreation was unterested to the recreation was recreated to the recreated to the recreation was recreated to the	ere ensive ensive esing, resonal falls prior ior to admission et 1, the falling rway or at ervation. 3 was not sk for vas to wear ff was 13 or when 13's care				
	R213 was allowed	rders dated 8/10/21 out of his room durii riod which began 7/	ng the 14				
	R213's door, which droplet and contact isolation gown, mas	o.m. signage was ob indicated R213 was precautions, and re sk, eye protection, a 13's room. R213 w tt that time.	s on equired an and gloves				
	station on the Rapid mask did not cover was down around F	o.m. R213 sat at the d Recovery unit., an R213's nose or mo R213's chin. Staff a erved to walk by R2	nd R213's outh but nd				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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21390	than six from R213 main pathway by the On 8/9/21, at 7:05 pstated R213 was and had not received RN-G stated before needed was a gown protection. On 8/9/21, at 7:09 psthreshold of his root table. During supported (NA)-F was observed from R213 outside assisted R213 with fork. NA-F wore eye mask; but did not we respirator. RN-D at instructed NA-F to ployees on when wo On 8/9/21, at 7:10 pshave donned an isot assisting R213 with On 8/9/21, at 7:11 pshave done	R213 while R213 sat e nurses desk. o.m. registered nurse (In quarantine for 14 day readmitted from the head the COVID 19 vaccine entering R213's roomn, N95 mask, gloves, and the mand ate supper on the meal, nursing assisted to stand less than sing for R213's doorway and supper by handing R2 e protection and a surguear a gown, gloves, or peroached NA-F and out an isolation gown a rking with R213.	RN)-G rs cospital ne. PPE nd eye of the ne tray ant ix feet I 13 his ical N95 nd should s while s was on ns cospital ne. In gown, working d she rn and per.	21390			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMP	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
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 ecorded 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		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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21390	Continued From pa	nge 7	21390			
	shields.					
	assisted R213 with stated she did not wassisted R213 into one. NA-D stated so N95. Review of facindicated NA-D had On 8/12/21, at 9:59 assisted R213 into wear an N95 mask mask when she assisted she had not respirator. On 8/12/21, at 11:5 (PT)-A was observed respirator in the edition of the control of the	a.m. NA-D stated she a transfer into bed. NA-D wear an N95 when she bed and should have worn she had been fit tested for cility documentation however, d not been N95 fit tested. a.m. NA-E stated she had bed and verified she did not , and only wore a surgical sisted R213 into bed. NA-E been fit tested to wear an N95 6 a.m. physical therapist ed being fit tested for an N95 ucation room. At 8/12/21, at cited the education room and fit tested for a N95 respirator about the testing that day.				
		I worked with residents in and prior to that had not been				
	N95 fit tested.	•				
	employees and ind N95 fit tested. The reviewed and comp who were not N95 shift for 8/9/21 and	29 p.m. RN-E provided list of icated the ones who were not a facilities staff scheduled was pared to the list of employees fit tested, revealed on the night 8/11/21, none of the 12 staff een fit tested for use of an N95				
	expectation staff who quarantine to be NS	p.m. DON stated it was the ho worked with residents on 95 fit tested and wear an N95 N further stated if staff were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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21390	not fit tested for an exclusions to wear not enter any rooms. On 8/13/21, at 11:4 on Falling Stars due poor judgement, an required to be in lin was on quarantine readmission, was unusued out of his readmission, was unusued out of his wheelchastated there were not allowed out of his wheelchastated there were not allowed the nurse's station of his doorway so staff. The facility policy Not Confirmed Corona 8/13/21, directed to readmitted resident risk, and/or cognition unless they are fully updated to also including fit testing for respirators upon his direct contact with respirators and respirators upon the direct and respirators upon the direct contact with respirators and respirators upon the direct contact with respirators and respirators upon the direct contact with respirators upon the direct contact	N95 respirator or had medical an N95 respirator, staff should son quarantine. 4 a.m. RN-F stated R213 was to R213's impulsiveness, disubsequent falls and to of sight. RN-F stated R213 because R213 was a nvaccinated and required a RN-F stated R213 was boom because R213 would get ir and attempt to stand. RN-F or designated staff assigned to the staff would just tag sometimes RN-F would sit at and other times R213 sat in frould see R213. Idanagement of Suspected or Virus (COVID-19) revised quarantine all admitted and the staff see of diagnosis, fall on in their rooms for 14 days of vaccinated. The policy was ude, the facility would also be employees on the use of N95 are if that employee will be in residents or will have the need the room.	21390			
	admitted on 8/5/21.					
	indicated R311's dia (paralysis of one side	agnosis List printed 8/13/21, agnoses included hemiplegia de of the body) of left dysphagia (difficulty				

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21390	swallowing food an type II, depression, ateriovenous malfo (an abnormal conn brain or spine). R311's care plan in R311 would remain upon admission or during the pandem On 8/9/21, at 6:27 rooms was observe Nursing assistant (personal protective bringing R311 a m (RN)-B could be he inside R311's room to hang her isolation next time she need When RN-B exited interviewed, RN-B re-using an isolatio practice but had be four times already. re-using her isolation facility did not have gowns. On 8/9/21, at 6:36 acceptable practice quarantine room ar On 8/13/21, at 11:3 (DON) verified it wastaff to re-use isolation.	d liquids), diabetes mellitus morbid obesity, and armation of cerebral vessels ection of blood vessels in the litiated on 8/5/21, directed on a 14 day room restriction readmission to the facility ic. p.m. the dinner tray service to ed on the Pinecone Lodge unit. NA)-A was observed donning equipment (PPE) prior to eal tray. Registered nurse eard talking to NA-A from an EN-B stated she was going in gown in the room to use the led to enter R311's room. The room she was verified she was unsure if in gown was acceptable een in/out of the room at least RN-B verified she was on gown, she verified the ear a shortage on isolation on the continue to use them. 4 a.m. the director of nursing as not acceptable practice for tion gowns.	21390				
		ident with Confirmed or 19 directed staff to discard the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ъ. І`′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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21390	90 Continued From page 10			90			
	isolation gown in a waste container or hamper after removing.						
	indicated R5's diagrurinary tract infections shock (a potentially occurs when the bodamages its own tist chronic kidney disecurine. R5's quarterly Minimassessment dated severe cognitive imcatheter, had a uring	mary Sheet printed 8/12/noses included a history ons, severe sepsis with solife-threatening conditionary's response to an infersues), acute kidney fail ase, diabetes, and reterment Data Set (MDS) 5/5/21, indicated R5 had pairment, had an indwer ary tract infection (UTI) epsis. R5 required external cares.	of septic on that ection ure, ation of ling in the				
	-Change specified of urine -Do not irrigate Fold for leaking or decre similar sized cathet tubing prior to obtain sample. May attack re-attach to straight only when instructe regular flush when a re-foley catheter care. R5's care plan initiate of infections related catheter cares and bag to be hung below.		ention needed ng d ulture ed then Flush s's risk ected ter times,				

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21390	R5's nursing assistate worksheet/community NA's to provide cather needed, but lacked catheter and to ensibag was kept off the R5's Interdisciplinar care conference on been hospitalized from with a UTI and sepsion of the With a UTI and sepsion of	ant (NA) inication dated 8/11/21, directives for positioning of the R5's catheter drainage of floor. Ty Notes dated 8/11/21, for 8/10/21, indicated R5 had om 6/6/21, through 6/9/21 sis. The drainage bag sitting on the drainage bag sitting on the floor. The drainage bag sitting on the drainage bag of the floor. The drainage bag sitting on the floor and the floor. The drainage bag sitting on the floor and the floor and the floor and the floor. The drainage bag sitting on the floor and the floor and the floor and the floor and the floor. The drainage bag was we hanged. NA-C washed under cares using proper floor and the floor and f	as of e			

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21390	Continued From particles of Nursel Suggested and risk of infection. On 8/12/21, at 9:20 catheter drainage by bag, and hung it un verified R5's catheter and stated she did R5's case manager drainage bags, ever should not be hang to risk of infection. On 8/12/21, at 10:2 (RN)-C verified cath bag should not be to the should	a.m. LPN-A channag, placed it in a coder R5's wheelchaller tubing had sedimot like that, so worder. LPN-A verified the not like that, so worder. LPN-A verified the notation of the touched the sedimonal of the touched the sedimonal of the touching the floor. p.m. director of note the december of the term of the transage bags and were not touching the sedimonal of the touching the sedimonal of the touching	elean privacy air. LPN-A ment in it buld talk to ne catheter y bag, ne floor due nurse y and privacy ursing s should be tamination Urinary directives to I tubing the floor or CTION: could s and ng all could could could congoing	21390			
	(21) days.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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21426	Continued From pa	nge 13		21426			
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control			21426			9/27/21
	 (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 Requirem by: Based on interview facility failed to ens step Tuberculin skirto check for tubercu completed timely for TST.	and document re ure an employee' n test (TST) (a sk ulosis infection) w	eview, the s second in test used vas		Corrected		
	Findings include:						
	Trained medication Tuberculin (TB) Sc						

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21426	6 Continued From page 14			21426			
	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 T	uberculosis					

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21426	second step TST casuggested of one to than 365 days. SUGGESTED MET The Director of Nur develop, review, an procedures to ensurand testing for staff according to the Corecommendations. The Director of Nur educate all appropring procedures. The Director of Nur develop monitoring compliance.	ge 15 ses revised 6/21, directed an have a time frame of three weeks, but not greater and three weeks, but not greater and three weeks, but not greater and the folial and	21426			

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

F5330030

Printed: 09/08/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED	
		245330	245330		B. WING		08/12/2021	
COUNTRY MANOR HEALTH & REHAB CTR 520 FIF				RESS, CITY, STATE, ZIP CODE RST STREET NORTHEAST ELL, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	SHOULD BE COMPLETION		
K 000	FIRE SAFETY			K 000				
	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 souther determined to be of 1996 an addition was determined to construction. In 200 the Main Entrance/be of Type V(111) of two-story addition was determined to be of Because the original	east of 300 Wing that Type V(111) construes as added to the Kitches as added to the Kitches of Type V(111) an addition was accepted that was deternionstruction. In 2011	t was uction. In nen that dded to nined to a uction. dditions					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATU					TITLE		(X6) DATE	

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

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING COMPLETED 245330 B. WING_ 08/12/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER COUNTRY MANOR HEALTH & REHAB CTR **520 FIRST STREET NORTHEAST** SARTELL, MN 56377 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) K 000 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.