DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 30, 2023

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

RE: CCN: 245550
Cycle Start Date: September 14, 2023

Dear Administrator:

On November 21, 2023, we notified you a remedy was imposed. On October 18, 2023 the Minnesota Departments 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 November 7, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 14, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 21, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 14, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 7, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2023

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

RE: CCN: 245550
Cycle Start Date: September 14, 2023

Dear Administrator:

On September 14, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 14, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 14, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

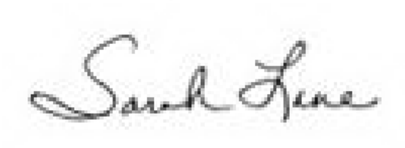
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	C 09/14/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/11/23 through 9/14/23, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed H55505387C (MN90602), H55505388C (MN94036), H55505384C (MN92187) and H55505385C (MN94896) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		10/10/23

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

Electronically Signed | 10/06/2023

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

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F 880	Continued From page 1 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 2 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, failed to implement timely transmission based precautions (TBP) and testing according to the Centers for Disease Control (CDC) for 2 of 2 residents (R6, R33, R27) who were displaying COVID-19 symptoms; and the facility failed to conduct COVID-19 outbreak testing was conducted according to CDC guidance for 13 staff (DA-B, C-A, C-B, HSK-A, BUS-A, BUS-B, SS-A, MED-A, NA-J, NA-K, NA-L, NA-M and NA-N) who worked without participating in outbreak testing; and failed to ensure surveillance tracking of infections was completed for staff and residents. This had the potential to affect all residents and staff. Findings include: The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 5/8/23, identified	F 880	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. All staff were informed via text that they will need to test for COVID-19 before entering the building. Supplies were stocked in the employee entrance and employees were instructed to wait for their test results in their vehicle. Test results are recorded in the logbook and verbally validated by trained staff. Trained staff were educated on what symptoms to look for and validation of negative test. All staff also need to check in at the Kiosk and confirm that they have no COVID symptoms. The logbook audited daily for validation of staff working in the last 24 hours. On weekdays this is done by administration and on weekends by the charge nurse. Staff who are not following the proper check-in procedure are	

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F 880	Continued From page 3 when performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction ' s public health authority. - A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. - The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. - Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period. - In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be	F 880	contacted by their supervisor and disciplinary action will be initiated according to the progressive discipline policy. Staff were reeducated via text about the protocol they should follow if they have symptoms. Date Corrected: 9/14/2023 An email was sent to all licensed nurses reeducating them on protocol for COVID positive and symptomatic residents. Date Corrected: 9/15/2023 How the facility will identify other residents having the potential to be affected by the same deficient practice. We have identified that all residents in our facility have the potential to be affected. Date Corrected: 9/14/2023 What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The following facility policies were updated to reflect current CDC guidance: Staff Mass Testing for COVID-19, PPE for COVID-19 Precautions/Testing, and Pandemic Respiratory Surveillance and Identification for Residents and Staff. Date Corrected: 10/3/2023	

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F 880	Continued From page 4 given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction ' s public authority recommends these and additional precautions. - If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. - If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered. The CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 updated 9/23/22, identified HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays. When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. If using NAAT (molecular), a single negative test is sufficient in	F 880	Staff education was emailed to all staff regarding surveillance of residents for COVID-19 symptoms, surveillance of staff for COVID-19 symptoms, staff testing during an outbreak, and transmission-based precautions. A text was sent to all staff to tell them to check their emails and respond to the Staff Development Coordinator with confirmation of understanding. Date Corrected: 10/10/2023 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Outbreak Staff testing: Administrator will audit staff testing logbook and follow up with managers to ensure appropriate disciplinary action is taken for non-compliant staff. This will be completed once weekly until the facility is conducting outbreak testing for the next 6 months. Symptomatic Testing Staff: The administrator will audit ICP’s symptomatic staff spreadsheet weekly for 1 month, biweekly for 2 months and monthly for 3 months to confirm symptomatic staff have two negative antigen tests 48 hours apart or a negative PCR test before returning to work. Symptomatic Testing Residents: DON or designated employee will audit during the	

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F 880	Continued From page 5 most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT. If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses. R6's significant change in status Minimum Data Set (MDS) dated 6/16/23, identified R6 was 84 years old and had intact cognition. Diagnoses included diabetes, peripheral vascular disease, and cardiomyopathy. During observation on 9/12/23 at 4:14 p.m. a PPE cart was outside R6's room and a contact precautions sign on the residents door. LPN-F stated R6 was not feeling well and tested positive for COVID-19 earlier that day. R6's nursing progress note dated 9/12/23 at 4:35 p.m., identified R6 complained of weakness, exhaustion and headache. COVID-19 positive. During interview on 9/12/23 at 5:06 p.m., LPN-F stated she recently tested R6 for COVID-19. LPN-F stated she wore a surgical mask, gloves and prescription glasses when she administered the COVID-19 antigen test. LPN-F stated she did not wear a gown, N95 mask or eye protection other than prescription eye glasses. During interview on 9/14/23 at 3:07 p.m., the	F 880	daily review of progress notes that staff are implementing proper precautions and testing symptomatic residents for COVID-19. A line item will be added to the IDT meeting notes to review precautions for symptomatic residents. Date Corrected: 10/3/2023	

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F 880	Continued From page 6 director of nursing (DON) stated staff are expected to wear full PPE when testing residents for COVID-19. R33's quarterly MDS dated 7/14/23, identified R33 was 92 years old and had a severe cognitive impairment. Diagnoses included atrial fibrillation (irregular heartbeat), hypertension, and anemia. R33's nursing progress notes dated 9/11/23 at 12:50 p.m., identified R33's testing for the facility's COVID-19 outbreak was negative. - On 9/12/23 at 1:24 p.m., R33 was seen during doctor rounds and staff were awaiting orders. The note did not identify R33's symptoms. - On 9/12/23 at 7:42 p.m., staff toileted R33 at 3:00 p.m., and was R33 was weak and shaky. R33 required assist of two persons to transfer to toilet. R33 had loose stools with scant amount of blood due to hemorrhoids. The nurse was updated and the nurse attempted to test for COVID; however, R33 refused by turning head away from staff and stating "no". Reassessed R33 at this time. Blood pressure (BP) 168/82, temperature 98.9 degrees Fahrenheit (F), pulse 76, respirations 18, and oxygen saturations 96%. R33's lung sounds were clear throughout with no cough noted. Staff were unable to determine if R33 had other symptoms such as congestion or sore throat. R33 allowed a COVID-19 test be to be completed at 7:30 p.m. which resulted positive. R33 had been in her room that shift. On 9/12/23 at 4:53 p.m., licensed practical nurse (LPN)-F stated R33 was feeling weak, clammy, tired and had diarrhea. LPN-F entered R33's room wearing a surgical face mask, prescription glasses and was carrying a COVID-19 test.	F 880		

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F 880	Continued From page 7 LPN-F placed the COVID-19 test kit on the dresser, walked around to the right side of R33's bed, leaned down and reached under R33's right shoulder to physically lift and adjusted the residents head towards the middle of the bed and onto the pillow. LPN-F walked back towards the dresser that was on the left side of the bed. LPN-F put gloves on, picked up the COVID-19 nasal swab, leaned over the left side of the bed and reached across the residents body to insert the swab into R33's nares. State Agency (SA) intervened. LPN-F stopped the testing effort and stated when conducting a COVID-19 test on a resident staff should wear full PPE including a gown, gloves, N95 mask and eye protection other than prescription glasses. LPN-F exited R33's room, threw the unused COVID-19 test into the garbage, used hand sanitizer and went to get another COVID-19 antigen test. LPN-F returned with a new COVID-19 test, donned full PPE, entered residents room, prepped supplies and attempted to swab R33's nares for the test. R33 turned her head down toward the blanket and refused multiple times to have the test administered. LPN-F stood, walked from the bed, threw the unused COVID-19 testing swab in the garbage, removed and disposed of the PPE she had been wearing. During observations on 9/12/23 at 5:20 p.m., R33 was in her room however, there was no sign on R33's door identifying TBP or supplies for TBP outside the door. -at 5:23 p.m. R33's call light was turned on. Nursing assistant (NA)-P and NA-M entered R33's room without putting on personal protective equipment (PPE) (isolation gown, gloves, goggles, and N95 mask). -at 5:26 p.m. NA-P and NA-M exited R33's room	F 880		

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	245550	A. BUILDING _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 8 and proceeded to help other residents. -at 5:27 p.m. R33's call light was turned on and NA-I entered room without putting on PPE. Then NA-I exited the room and turned the call light off. -at 5:28 p.m. R33's call light was turned on. -at 5:29 p.m. NA-M entered R33's room and did not put PPE on. -at 5:30 p.m. NA-P entered R33's without putting on PPE. -at 5:31 p.m. NA-M exited R33's room and entered two separate units to assist residents to supper. -at 5:32 p.m. NA- exited R33's room and proceeded to assist other residents in the facility. -at 8:01 p.m. R33 was in their room and on TBP. During interview on 9/12/23 at 8:00 p.m., LPN-F stated R33 allowed staff to administer the COVID test and R33 tested positive for COVID-19. R27's annual MDS dated 7/28/23, identified R27 was 101 years old, had severe cognitive impairment. Diagnoses included Alzheimer's disease, hypertension, and anxiety. R27's nursing progress note dated 9/11/23 at 12:49 p.m., identified R27's testing for the facility's COVID-19 outbreak was negative. During observation on 9/12/23, at 4:44 p.m. R27 was wheeling around in the common area with other residents around. R27 was not on TBP. During an interview on 9/13/23 at 4:30 p.m., the DON stated she identified R27 had symptoms of a cough and runny nose on 9/10/23, was tested with an antigen test which resulted as negative. R27 was again tested on 9/11/23. R27 was not placed into isolation due to symptoms until a	F 880		

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F 880	Continued From page 9 confirmatory test was collected after 48 hours on 9/12/23. R27's medical record nor the infection prevention surveillance logs identified this. The DON stated she expected staff to notify the IP of all possible infections and also expected the tracking and tending of all infections to prevent possible transmission. R27's medical record lacked information related to the signs and symptoms of potential COVID-19 infection. The facility Infection Surveillance log for September 2023, identified the onset date, resident name and room number, infection site, symptoms/signs, test culture pathogen, diagnosis and antibiotic order/physician-provider. The data included R29's COVID-19 diagnosis; however, the log did not include R6, R33, nor R27 for COVID-19. During an interview on 9/13/23 at 11:22 a.m. RN-A and LPN-B stated whenever a resident exhibited any sign/symptom of illness they would complete an assessment, an "overall check". Does the resident have a fever and/or cough? LPN-B stated at that time they would also collect a COVID-19 antigen test. If the test was negative, staff might call the provider and also enter a nursing progress note. LPN-B nor RN-A stated they would notify the IP or the DON if the test was negative. RN-A stated she would never place a symptomatic resident who had tested negative for COVID-19 into isolation because that would be unwarranted nor was a confirmatory test required. RN-A stated R33 was tested on 9/11/23, due to being symptomatic, was not placed into isolation, was seen by the provider, but tested positive the evening of 9/12/23. At that time, R33 was placed	F 880		

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F 880	Continued From page 10 into isolation because she was confirmed positive for COVID-19. During an interview on 9/14/23 at 12:48 p.m., the IP stated she normally attended the Interdisciplinary Team Meeting (IDT) and was informed of possible infections. Upon review of the September Infection Surveillance log, the IP stated it was up to date until the evening of 9/12/23. The IP did not usually put all symptoms on the tracking log because some things would resolve without treatment. STAFF ILLNESS: During an interview on 9/13/23 at 1:13 p.m., NA-D stated on 9/12/23, NA-D felt hot/cold, just not feeling well. NA-D tested at home and was negative for COVID-19. NA-D told the nurses during report she tested negative on 9/12/23, at home then tested in the facility on 9/13/23, with an antigen test. If NA-D had continuing symptoms NA-D would have stayed home but tested negative so came to work as usual. Staff only needed to stay home if they tested positive. NA-D received an email that would "pop" up on her phone telling her when to test. Staff used to test twice a week, but she really did not know anymore. The facility's infection preventionist (IP) had not told the staff yet when they were supposed to test again but would probably tell them later in the week. NA-D could not say who she reported to her symptoms and test to. NA-D illness symptoms and home test were not listed on the September staff illness log. During an interview on 9/13/23 at 1:15 p.m.,	F 880		

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F 880	Continued From page 11 LPN-B stated she found out she needed to wear a mask in the facility when she had arrived to work on 9/12/23, and someone told LPN-B there was COVID-19 in the building and everyone had to test. That morning on 9/13/23, the IP told everyone over the walkie-talkie to test again. LPN-B stated she did not work at the facility often and just knew she had to test every time she worked. During an interview on 9/13/23 at 1:17 p.m., DA-A stated staff had to test and wear a surgical mask in the building because there was COVID-19. DA-A stated he thought staff had to test twice a week but was not really sure. Staff received an email and the nurses gave verbal reminders too. During an interview on 9/13/23 at 1:18 p.m., RN-A stated she found out she needed to test for COVID-19 while she was in morning report with the other staff. Staff used to come to work early and they had to know their results before starting work, but that morning RN-A just went to the nurses' station to test. Outbreak testing used to be twice a week but she would test whenever she was told to. During an interview on 9/13/23 at 10:40 a.m., the facility IP stated staff had to follow the facility's call-in procedure. All staff had to report to the charge nurse. The charge nurse filled out an absence form and then gave the form to the IP because she did payroll duties as well. The absence form was for any type of absence, tardy, etc. The charge nurse gave the form to the department supervisor who signs the form and forwards it to the IP. At the time, the IP would do a follow up with the staff member. Most supervisors emailed the IP to let her know and	F 880		

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F 880	Continued From page 12 she would look at her email Monday through Friday between 8:00 a.m. and 3:00 p.m. when she was in the facility. For example, if she received an email at 4:00 p.m. on Friday, the IP would not read that email until Monday morning. For immediate weekend or after hour concerns, the staff should send a text to the IP; however, it really depended on the supervisor and/or department because not all departments worked weekends or aft/er hours. The nurses should collect all the data they needed /and go forward with whatever option they thought was best for them. Nursing did not call the IP with any questions because there was an on-call RN as well. - The facility utilized COVID-19 antigen tests on the staff and residents. Staff would come to the IP office and swab themselves, then the IP would complete the rest of the test. Any staff member would always have access to a test. If the IP was working, staff would swab and test themselves, then record the results on the testing sheets. The IP collected the sheets every day. Additionally, staff were able to test at home with an over-the-counter test. - NA-A reported symptoms in the afternoon on 9/9/23. NA-A worked that day and also worked 9/8/23. NA-A's family member who lived with NA-A tested positive so NA-A wore a surgical mask on 9/8/23 and 9/9/23. NA-A reported to the nurses station, tested positive and was sent home. Because 9/9/23, was a Saturday, nursing emailed the IP. - On 9/11/23, the IP put signs on the doors identifying the facility was in outbreak status and conducted whole house testing with the residents and staff in the building because it was too difficult to identify potential high risk exposures. However, there were additional staff positive	F 880		

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F 880	Continued From page 13 COVID-19 cases. LPN-A tested positive at home on 9/10/23. LPN-A tested positive at home on 9/10/23. Trained medication assistant (TMA)-A reported "sneezing and tired" on 9/10/23. She worked 9/9/23, 9/10/23 and 9/11/23. On 9/11/23, TMA-A was tested at the facility, was positive, and was sent home. LPN-C tested positive at home as well on 9/10/23. LPN-C last worked in the facility on 9/8/23; however, the absence form did not identify symptoms or when symptoms started. - All staff who worked tested because they knew to test; however, the IP did not go back through the testing log to verify all staff tested. New testing guidance was distributed in August 2023, but she had not reviewed the guidance and would need to look it up. On 9/11/23, IP sent an email to everyone telling them to test prior to work and to wear a mask. Staff were able to test any time during their shift. If they started work at 7:00 a.m., they could test at 10:00 a.m. The IP kept all the Staff Testing: BinaxNOW COVID-19 Ag Card lists in a binder in her office and also kept a running list. The IP told the department managers to remind their staff; however the IP did not review schedules to verify all staff tested. Since 9/11/23, the IP was unaware of any staff who had not tested. At the end of the outbreak, the IP would review the working list and put together an email for all the managers. The IP would do this whenever the IP had time. COVID-19 testing during an outbreak was important to ensure asymptomatic staff were not carrying the COVID-19 virus because it could lead to transmission to other staff and residents. The facility Staff Testing: BinaxNOW COVID-19 Antigen (Ag) Cards identified the following: - On 9/9/23, NA-A tested positive.	F 880		

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F 880	Continued From page 14 - On 9/10/23, the following tested negative: LPN-E, trained medication assistant (TMA)-A, and NA-E. The following tested positive: TMA-A. - On 9/11/23, the following tested negative: LPN-A, LPN-D, LPN-E, NA-E, NA-F, and NA-G. - On 9/12/23, the following tested negative: registered nurse (RN)-B, LPN-B, and NA-H. - On 9/13/23, the following tested negative: NA-F and NA-I The facility staff illness log for September 2023, identified the following: - On 9/9/23, NA-A complained of a headache and chills. NA-A had an exposure to COVID-19 at home and had tested negative on 9/8/23. The cautionary measures were "stay out of work". The log did not identify what type of test was conducted, when NA-A had worked in the facility and/or any potential high risk exposures. - 9/11/23, licensed practical nurse (LPN)-A complained of a headache and congestion and tested positive for COVID-19 at home. The cautionary measures were "stay out of work". The log did not identify what type of test was conducted, when LPN-A had worked in the facility and/or any potential high risk exposures. - On 9/12/23, NA-B complained of congestion and fatigue. NA-B had reported a negative COVID-19 test was done at home on 9/11/23 and 9/12/23. The cautionary measures were "stay out of work". The log did not identify what type of test was conducted, when LPN-A had worked in the facility and/or any potential high risk exposures. - On 9/13/23, NA-C complained of cough. NA-C tested negative for COVID-19 on 9/12/23. The log did not identify what type of test was conducted, when LPN-A had worked in the facility and/or any potential high risk exposures.	F 880		

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F 880	Continued From page 15 The staff log failed to identify LPN-B nor TMA-A's illnesses or positive COVID-19 tests The facility provided staff testing log and the staff schedules for 9/11/23, 9/12/23 and 9/13/23, identified the following staff worked without participating in outbreak testing prior to their shift: - dietary aide (DA)-B worked on 9/12/23 and did not test. - cook (C)-A worked 9/12/23 and 9/13/23 and did not test. - C-B worked 9/12/23 and did not test. - housekeeper (HSK)-A worked 9/12/23 and 9/13/23 and did not test. - business office (BUS)-A worked on 9/11/23, 9/12/23, and 9/13/23 and did not test. - BUS-B worked 9/11/23, 9/12/23, and 9/13/23 and did not test. - social services (SS)-A worked 9/11/23, 9/12/23, and 9/13/23 and did not test. - medical records (MED)-A worked 9/12/23 and 9/13/23 and did not test. - NA-J worked 9/11/23 and did not test. - NA-K worked 9/11/23 and did not test. - NA-L worked 9/11/23 and did not test. - NA-M worked 9/11/23 and did not test. - NA-N worked 9/12/23 and 9/13/23 and did not test. During an interview on 9/14/23 at 1:30 p.m., director of nursing (DON) stated she expected staff to notify the IP nurse of all possible infection symptoms and also for all infection symptoms to be tracked to prevent possible transmission of communicable disease. The facility policy Staff Mass Testing for COVID-19 revised 2/21/22, identified testing completed at the facility would be at no cost to the	F 880		

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F 880	Continued From page 16 staff. In the event of this pandemic, the facility would mandate testing for all staff. COVID testing could be done by RT-PCR (NAAT) or by antigen test. The policy lacked to identify when a symptomatic staff member should report symptoms and test, when to stay out of the facility, when a confirmatory test should be collected, nor frequency of outbreak testing. The facility policy Resident Mass Testing for COVID-19 revised 12/15/22, identified COVID testing could be done by RT-PCR or antigen testing. Residents that had not consented would be clearly indicated and no resident would be restrained or forced to complete the test. Residents who refused would be educated about the current COVID status in the facility and about proper PPE use for residents. The resident would be monitored for any COVID symptoms and placed under transmission based precautions if any symptoms arose. However, the policy did not direct staff to collect confirmatory tests for symptomatic residents who had tested negative nor directed staff to place symptomatic residents into isolation until a confirmatory test could be collected in a timely manner.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: XMDU11

Dear Administrator:

The above facility was surveyed on September 11, 2023 through September 14, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

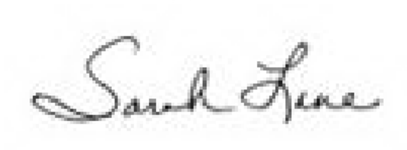
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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 feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/11/23 through 9/14/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H55505384C (MN92187) H55505387C (MN90602), H55505388C (MN94036) H55505385C (MN94896) with no licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 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. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, failed to implement timely transmission based precautions (TBP) and testing according to	21375	Corrected	10/10/23

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21375	Continued From page 3 the Centers for Disease Control (CDC) for 2 of 2 residents (R6, R33, R27) who were displaying COVID-19 symptoms; and the facility failed to conduct COVID-19 outbreak testing was conducted according to CDC guidance for 13 staff (DA-B, C-A, C-B, HSK-A, BUS-A, BUS-B, SS-A, MED-A, NA-J, NA-K, NA-L, NA-M and NA-N) who worked without participating in outbreak testing; and failed to ensure surveillance tracking of infections was completed for staff and residents. This had the potential to affect all residents and staff. Findings include: The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 5/8/23, identified when performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction ' s public health authority. - A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. - The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. - Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is	21375		

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21375	Continued From page 4 recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period. - In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of Empiric use of Transmission-Based Precautions for residents and work restriction of HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction ' s public authority recommends these and additional precautions. - If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. Empiric use of Transmission-Based Precautions for residents and work restriction for HCP who met criteria can be discontinued as described in Section 2 and the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, respectively. - If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part	21375		

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21375	Continued From page 5 of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered. The CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 updated 9/23/22, identified HCP with even mild symptoms of COVID-19 should be prioritized for viral testing with nucleic acid or antigen detection assays. When testing a person with symptoms of COVID-19, negative results from at least one viral test indicate that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. If using NAAT (molecular), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT. If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. For HCP who were initially suspected of having COVID-19 but, following evaluation, another diagnosis is suspected or confirmed, return-to-work decisions should be based on their other suspected or confirmed diagnoses. R6's significant change Minimum Data Set (MDS) dated 6/16/23, identified R6 was 84 years old and had intact cognition. Diagnoses included diabetes, peripheral vascular disease, and cardiomyopathy. During observation on 9/12/23 at 4:14 p.m. a PPE cart was outside R6's room and a contact	21375		

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21375	Continued From page 6 precautions sign on the residents door. LPN-F stated R6 was not feeling well and tested positive for COVID-19 earlier that day. R6's nursing progress note dated 9/12/23 at 4:35 p.m., identified R6 complained of weakness, exhaustion and headache. COVID-19 positive. During interview on 9/12/23 at 5:06 p.m., LPN-F stated she recently tested R6 for COVID-19. LPN-F stated she wore a surgical mask, gloves and prescription glasses when she administered the COVID-19 antigen test. LPN-F stated she did not wear a gown, N95 mask or eye protection other than prescription eye glasses. During interview on 9/14/23 at 3:07 p.m., the director of nursing (DON) stated staff are expected to wear full PPE when testing residents for COVID-19. R33's quarterly MDS dated 7/14/23, identified R33 was 92 years old and had a severe cognitive impairment. Diagnoses included atrial fibrillation (irregular heartbeat), hypertension, and anemia. R33's nursing progress notes dated 9/11/23 at 12:50 p.m., identified R33's testing for the facility's COVID-19 outbreak was negative. - On 9/12/23 at 1:24 p.m., R33 was seen during doctor rounds and staff were awaiting orders. The note did not identify R33's symptoms. - On 9/12/23 at 7:42 p.m., staff toileted R33 at 3:00 p.m., and was R33 was weak and shaky. R33 required assist of two persons to transfer to toilet. R33 had loose stools with scant amount of blood due to hemorrhoids. The nurse was updated and the nurse attempted to test for COVID; however, R33 refused by turning head	21375		

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21375	Continued From page 7 away from staff and stating "no". Reassessed R33 at this time. Blood pressure (BP) 168/82, temperature 98.9 degrees Fahrenheit (F), pulse 76, respirations 18, and oxygen saturations 96%. R33's lung sounds were clear throughout with no cough noted. Staff were unable to determine if R33 had other symptoms such as congestion or sore throat. R33 allowed a COVID-19 test be to be completed at 7:30 p.m. which resulted positive. R33 had been in her room that shift. On 9/12/23 at 4:53 p.m., licensed practical nurse (LPN)-F stated R33 was feeling weak, clammy, tired and had diarrhea. LPN-F entered R33's room wearing a surgical face mask, prescription glasses and was carrying a COVID-19 test. LPN-F placed the COVID-19 test kit on the dresser, walked around to the right side of R33's bed, leaned down and reached under R33's right shoulder to physically lift and adjusted the residents head towards the middle of the bed and onto the pillow. LPN-F walked back towards the dresser that was on the left side of the bed. LPN-F put gloves on, picked up the COVID-19 nasal swab, leaned over the left side of the bed and reached across the residents body to insert the swab into R33's nares. State Agency (SA) intervened. LPN-F stopped the testing effort and stated when conducting a COVID-19 test on a resident staff should wear full PPE including a gown, gloves, N95 mask and eye protection other than prescription glasses. LPN-F exited R33's room, threw the unused COVID-19 test into the garbage, used hand sanitizer and went to get another COVID-19 antigen test. LPN-F returned with a new COVID-19 test, donned full PPE, entered residents room, prepped supplies and attempted to swab R33's nares for the test. R33 turned her head down toward the blanket and refused multiple times to have the test	21375		

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21375	Continued From page 8 administered. LPN-F stood, walked from the bed, threw the unused COVID-19 testing swab in the garbage, removed and disposed of the PPE she had been wearing. During observations on 9/12/23 at 5:20 p.m., R33 was in her room however, there was no sign on R33's door identifying TBP or supplies for TBP outside the door. -at 5:23 p.m. R33's call light was turned on. Nursing assistant (NA)-P and NA-M entered R33's room without putting on personal protective equipment (PPE) (isolation gown, gloves, goggles, and N95 mask). -at 5:26 p.m. NA-P and NA-M exited R33's room and proceeded to help other residents. -at 5:27 p.m. R33's call light was turned on and NA-I entered room without putting on PPE. Then NA-I exited the room and turned the call light off. -at 5:28 p.m. R33's call light was turned on. -at 5:29 p.m. NA-M entered R33's room and did not put PPE on. -at 5:30 p.m. NA-P entered R33's without putting on PPE. -at 5:31 p.m. NA-M exited R33's room and entered two separate units to assist residents to supper. -at 5:32 p.m. NA- exited R33's room and proceeded to assist other residents in the facility. -at 8:01 p.m. R33 was in their room and on TBP. During interview on 9/12/23 at 8:00 p.m., LPN-F stated R33 allowed staff to administer the COVID test and R33 tested positive for COVID-19. R27's annual MDS dated 7/28/23, identified R27 was 101 years old, had severe cognitive impairment. Diagnoses included Alzheimer's disease, hypertension, and anxiety.	21375		

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21375	Continued From page 9 R27's nursing progress note dated 9/11/23 at 12:49 p.m., identified R27's testing for the facility's COVID-19 outbreak was negative. During observation on 9/12/23, at 4:44 p.m. R27 was wheeling around in the common area with other residents around. R27 was not on TBP. During an interview on 9/13/23 at 4:30 p.m., the DON stated she identified R27 had symptoms of a cough and runny nose on 9/10/23, was tested with an antigen test which resulted as negative. R27 was again tested on 9/11/23. R27 was not placed into isolation due to symptoms until a confirmatory test was collected after 48 hours on 9/12/23. R27's medical record nor the infection prevention surveillance logs identified this. The DON stated she expected staff to notify the IP of all possible infections and also expected the tracking and tending of all infections to prevent possible transmission. R27's medical record lacked information related to the signs and symptoms of potential COVID-19 infection. The facility Infection Surveillance log for September 2023, identified the onset date, resident name and room number, infection site, symptoms/signs, test culture pathogen, diagnosis and antibiotic order/physician-provider. The data included R29's COVID-19 diagnosis; however, the log did not include R6, R33, nor R27 for COVID-19. During an interview on 9/13/23 at 11:22 a.m. RN-A and LPN-B stated whenever a resident exhibited any sign/symptom of illness they would complete an assessment, an "overall check". Does the resident have a fever and/or cough?	21375		

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21375	Continued From page 10 LPN-B stated at that time they would also collect a COVID-19 antigen test. If the test was negative, staff might call the provider and also enter a nursing progress note. LPN-B nor RN-A stated they would notify the IP or the DON if the test was negative. RN-A stated she would never place a symptomatic resident who had tested negative for COVID-19 into isolation because that would be unwarranted nor was a confirmatory test required. RN-A stated R33 was tested on 9/11/23, due to being symptomatic, was not placed into isolation, was seen by the provider, but tested positive the evening of 9/12/23. At that time, R33 was placed into isolation because she was confirmed positive for COVID-19. During an interview on 9/14/23 at 12:48 p.m., the IP stated she normally attended the Interdisciplinary Team Meeting (IDT) and was informed of possible infections. Upon review of the September Infection Surveillance log, the IP stated it was up to date until the evening of 9/12/23. The IP did not usually put all symptoms on the tracking log because some things would resolve without treatment. STAFF ILLNESS: During an interview on 9/13/23 at 1:13 p.m., NA-D stated on 9/12/23, NA-D felt hot/cold, just not feeling well. NA-D tested at home and was negative for COVID-19. NA-D told the nurses during report she tested negative on 9/12/23, at home then tested in the facility on 9/13/23, with an antigen test. If NA-D had continuing symptoms NA-D would have stayed home but tested negative so came to work as usual. Staff only needed to stay home if they tested positive. NA-D received an email that would "pop" up on her	21375		

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21375	Continued From page 11 phone telling her when to test. Staff used to test twice a week, but she really did not know anymore. The facility's infection preventionist (IP) had not told the staff yet when they were supposed to test again but would probably tell them later in the week. NA-D could not say who she reported to her symptoms and test to. NA-D illness symptoms and home test were not listed on the September staff illness log. During an interview on 9/13/23 at 1:15 p.m., LPN-B stated she found out she needed to wear a mask in the facility when she had arrived to work on 9/12/23, and someone told LPN-B there was COVID-19 in the building and everyone had to test. That morning on 9/13/23, the IP told everyone over the walkie-talkie to test again. LPN-B stated she did not work at the facility often and just knew she had to test every time she worked. During an interview on 9/13/23 at 1:17 p.m., DA-A stated staff had to test and wear a surgical mask in the building because there was COVID-19. DA-A stated he thought staff had to test twice a week but was not really sure. Staff received an email and the nurses gave verbal reminders too. During an interview on 9/13/23 at 1:18 p.m., RN-A stated she found out she needed to test for COVID-19 while she was in morning report with the other staff. Staff used to come to work early and they had to know their results before starting work, but that morning RN-A just went to the nurses' station to test. Outbreak testing used to be twice a week but she would test whenever she was told to. The facility Staff Testing: BinaxNOW COVID-19	21375		

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21375	Continued From page 12 Antigen (Ag) Cards identified the following: - On 9/9/23, NA-A tested positive. - On 9/10/23, the following tested negative: LPN-E, trained medication assistant (TMA)-A, and NA-E. The following tested positive: TMA-A. - On 9/11/23, the following tested negative: LPN-A, LPN-D, LPN-E, NA-E, NA-F, and NA-G. - On 9/12/23, the following tested negative: registered nurse (RN)-B, LPN-B, and NA-H. - On 9/13/23, the following tested negative: NA-F and NA-I The facility staff illness log for September 2023, identified the following: - On 9/9/23, NA-A complained of a headache and chills. NA-A had an exposure to COVID-19 at home and had tested negative on 9/8/23. The cautionary measures were "stay out of work". The log did not identify what type of test was conducted, when NA-A had worked in the facility and/or any potential high risk exposures. - 9/11/23, licensed practical nurse (LPN)-A complained of a headache and congestion and tested positive for COVID-19 at home. The cautionary measures were "stay out of work". The log did not identify what type of test was conducted, when LPN-A had worked in the facility and/or any potential high risk exposures. - On 9/12/23, NA-B complained of congestion and fatigue. NA-B had reported a negative COVID-19 test was done at home on 9/11/23 and 9/12/23. The cautionary measures were "stay out of work". The log did not identify what type of test was conducted, when LPN-A had worked in the facility and/or any potential high risk exposures. - On 9/13/23, NA-C complained of cough. NA-C tested negative for COVID-19 on 9/12/23. The log did not identify what type of test was conducted, when LPN-A had worked in the facility and/or any potential high risk exposures.	21375		

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	00356	A. BUILDING: _____ B. WING _____	C 09/14/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 13 The staff log failed to identify LPN-B nor TMA-A's illnesses or positive COVID-19 tests The facility provided staff testing log and the staff schedules for 9/11/23, 9/12/23 and 9/13/23, identified the following staff worked without participating in outbreak testing prior to their shift: - dietary aide (DA)-B worked on 9/12/23 and did not test. - cook (C)-A worked 9/12/23 and 9/13/23 and did not test. - C-B worked 9/12/23 and did not test. - housekeeper (HSK)-A worked 9/12/23 and 9/13/23 and did not test. - business office (BUS)-A worked on 9/11/23, 9/12/23, and 9/13/23 and did not test. - BUS-B worked 9/11/23, 9/12/23, and 9/13/23 and did not test. - social services (SS)-A worked 9/11/23, 9/12/23, and 9/13/23 and did not test. - medical records (MED)-A worked 9/12/23 and 9/13/23 and did not test. - NA-J worked 9/11/23 and did not test. - NA-K worked 9/11/23 and did not test. - NA-L worked 9/11/23 and did not test. - NA-M worked 9/11/23 and did not test. - NA-N worked 9/12/23 and 9/13/23 and did not test. During an interview on 9/13/23 at 10:40 a.m., the facility IP stated staff had to follow the facility's call-in procedure. All staff had to report to the charge nurse. The charge nurse filled out an absence form and then gave the form to the IP because she did payroll duties as well. The absence form was for any type of absence, tardy, etc. The charge nurse gave the form to the department supervisor who signs the form and forwards it to the IP. At that time, the IP would do	21375		

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21375	Continued From page 14 a follow up with the staff member. Most supervisors emailed the IP to let her know and she would look at her email Monday through Friday between 8:00 a.m. and 3:00 p.m. when she was in the facility. For example, if she received an email at 4:00 p.m. on Friday, the IP would not read that email until Monday morning. For immediate weekend or after hour concerns, the staff should send a text to the IP; however, it really depended on the supervisor and/or department because not all departments worked weekends or aft/er hours. The nurses should collect all the data they needed /and go forward with whatever option they thought was best for them. Nursing did not call the IP with any questions because there was an on-call RN as well. - The facility utilized COVID-19 antigen tests on the staff and residents. Staff would come to the IP office and swab themselves, then the IP would complete the rest of the test. Any staff member would always have access to a test. If the IP was working, staff would swab and test themselves, then record the results on the testing sheets. The IP collected the sheets every day. Additionally, staff were able to test at home with an over-the-counter test. - NA-A reported symptoms in the afternoon on 9/9/23. NA-A worked that day and also worked 9/8/23. NA-A's family member who lived with NA-A tested positive so NA-A wore a surgical mask on 9/8/23 and 9/9/23. NA-A reported to the nurses station, tested positive and was sent home. Because 9/9/23, was a Saturday, nursing emailed the IP. - On 9/11/23, the IP put signs on the doors identifying the facility was in outbreak status and conducted whole house testing with the residents and staff in the building because it was too difficult to identify potential high risk exposures.	21375		

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21375	Continued From page 15 However, there were additional staff positive COVID-19 cases. LPN-A tested positive at home on 9/10/23. LPN-A tested positive at home on 9/10/23. Trained medication assistant (TMA)-A reported "sneezing and tired" on 9/10/23. She worked 9/9/23, 9/10/23 and 9/11/23. On 9/11/23, TMA-A was tested at the facility, was positive, and was sent home. LPN-C tested positive at home as well on 9/10/23. LPN-C last worked in the facility on 9/8/23; however, the absence form did not identify symptoms or when symptoms started. - All staff who worked tested because they knew to test; however, the IP did not go back through the testing log to verify all staff tested. New testing guidance was distributed in August 2023, but she had not reviewed the guidance and would need to look it up. On 9/11/23, IP sent an email to everyone telling them to test prior to work and to wear a mask. Staff were able to test any time during their shift. If they started work at 7:00 a.m., they could test at 10:00 a.m. The IP kept all the Staff Testing: BinaxNOW COVID-19 Ag Card lists in a binder in her office and also kept a running list. The IP told the department managers to remind their staff; however the IP did not review schedules to verify all staff tested. Since 9/11/23, the IP was unaware of any staff who had not tested. At the end of the outbreak, the IP would review the working list and put together an email for all the managers. The IP would do this whenever the IP had time. COVID-19 testing during an outbreak was important to ensure asymptomatic staff were not carrying the COVID-19 virus because it could lead to transmission to other staff and residents. During an interview on 9/14/23 at 1:30 p.m., DON stated she expected staff to notify the IP nurse of all possible infection symptoms and also	21375		

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21375	Continued From page 16 for all infection symptoms to be tracked to prevent possible transmission of communicable disease. The facility policy Staff Mass Testing for COVID-19 revised 2/21/22, identified testing completed at the facility would be at no cost to the staff. In the event of this pandemic, the facility would mandate testing for all staff. COVID testing could be done by RT-PCR (NAAT) or by antigen test. The policy lacked to identify when a symptomatic staff member should report symptoms and test, when to stay out of the facility, when a confirmatory test should be collected, nor frequency of outbreak testing. The facility policy Resident Mass Testing for COVID-19 revised 12/15/22, identified COVID testing could be done by RT-PCR or antigen testing. Residents that had not consented would be clearly indicated and no resident would be restrained or forced to complete the test. Residents who refused would be educated about the current COVID status in the facility and about proper PPE use for residents. The resident would be monitored for any COVID symptoms and placed under transmission based precautions if any symptoms arose. However, the policy did not direct staff to collect confirmatory tests for symptomatic residents who had tested negative nor directed staff to place symptomatic residents into isolation until a confirmatory test could be collected in a timely manner. SUGGESTED METHOD OF CORRECTION: The DON, IP or designated person could reviewed the CDC guidance on COVID-19 testing and transmission based precautions and review and update the facility policies, educate all staff and monitor for ongoing compliance.	21375		

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21375	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21375		

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	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/13/2023. At the time of this survey, North Star Manor was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/06/2023

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

North Star Manor was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This

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K 000	Continued From page 2 addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier. The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 The facility has a capacity of 45 beds and had a census of 36 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		11/7/23

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K 353	Continued From page 3 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/13/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation the facility failed to perform the quarter sprinkler system testing. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 353	K353 1. A detailed description of the corrective action taken or planned to correct the deficiency. Maintenace Director will be trained and qualified on quarterly sprinkler system testing by Johnson Controls on November 7th, 2023 at which time the quarterly sprinkler system maintenance will be completed. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. Maintenace Director will schedule quarterly WorxHub work orders for sprinkler system maintenance to ensure they are done in a timely manner. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Emergency Preparedness Coordinator will audit 4 times per year for one year for timeliness of inspection. This audit will be reported at quarterly Quality Assurance meetings to the QAPI committee.	

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K 353	Continued From page 4	K 353	4. Identify who is responsible for the corrective actions and monitoring of compliance. The Maintenace Director is responsible for correcting this deficiency through the above-mentioned actions. The Emergency Preparedness Coordinator is responsible for monitoring compliance with this regulation with the above-mentioned audits.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility.	K 372	K372 1. A detailed description of the corrective action taken or planned to correct the deficiency. The penetrations in the North Star Manor	9/13/23

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K 372	Continued From page 5 Findings include: On 09/13/2023between 9:30am and 12:30pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to apartments at end of 300 wing. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 372	Independent Apartments entrance smoke barrier wall and the North Star Manor 300 hallway smoke barrier wall were filled with fire graded caulking. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. All outside contractors will assign an attestation sheet certifying that they are responsible for filling in any penetrations they make in any wall. This will be monitored by the Maintenance Director at the time of work and verified after the work is completed. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The Maintenance Director will do quarterly inspections of smoke barriers. This audit will be reported at quarterly Quality Assurance meetings to the QAPI committee. 4. Identify who is responsible for the corrective actions and monitoring of compliance. The Maintenance Director is responsible for the corrective action through the above-mentioned actions and the monitoring of compliance through the above-mentioned audit. 5. The actual or proposed date for completion of the remedy.	

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K 372	Continued From page 6	K 372	9/13/2023	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/13/2023, between 09:30am and 12:30pm, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey.	K 761	K761 1. A detailed description of the corrective action taken or planned to correct the deficiency. The maintenance department immediately started and completed the annual fire door inspection. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. Maintenace Director is registered to complete NFPA fire door inspection	9/21/23

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 7 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	certification. The Maintenace Director trained maintenance assistants in proper inspection methods. Maintenace Director will schedule yearly WorxHub work orders for the annual fire door inspection to ensure they are done in a timely manner. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Emergency Preparedness Coordinator will audit next year's inspection to ensure they are completed prior to one year deadline. Report to QAPI 4. Identify who is responsible for the corrective actions and monitoring of compliance. The Maintenace Director is responsible for correcting this deficiency through the above-mentioned actions. The Emergency Preparedness Coordinator is responsible for monitoring compliance with this regulation with the above-mentioned audits. 5. The actual or proposed date for completion of the remedy. 9/21/2023	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245550	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**9/13/2023**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/13/2023 between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement. Fire drill documentation revealed missing times on fire drill documentation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents