DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 15, 2021

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

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 29, 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 informed you of imposed enforcement remedies.

On September 9, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effectiveSeptember 24, 2021, will remain in effect.

This Department continues to recommend 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, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 24, 2021.

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.

As we notified you in our letter of September 9, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 24, 2021.

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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division 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

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.

INFORMAL DISPUTE RESOLUTION/ 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.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245330	A. BUILDING _____ B. WING _____	C 09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY MANOR HEALTH & REHAB CTR	**520 FIRST STREET NORTHEAST SARTELL, MN 56377**

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F 000	INITIAL COMMENTS On 9/9/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints was found to be SUBSTANTIATED: H5330057C (MN76345) with a deficiency cited at F585 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585		10/4/21

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

Electronically Signed | 09/29/2021

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F 585	Continued From page 1 facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 585		

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F 585	Continued From page 2	F 585		

conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the

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F 585	Continued From page 3 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure voiced concerns about care were acted upon, assessed, and resolved to satisfaction for 1 of 1 resident (R1) who had complaints of rough treatment during transfers in and out of bed. Findings include: A provided Formal Grievances policy, undated, identified the facility recognized grievances may arise from residents and their families, and it listed an intent of dealing with such concerns effectively so all such situations could be addressed and resolved. The policy directed any grievance was to be brought to the department manager, or designee, and/or the Vice President of long-term care (LTC) and RR/AC. If unable to be resolved at that time, then the appropriate department supervisor was to be notified and a Country Manor Concern Intake Form completed with the nature of the grievance(s), any action(s) taken, and the initiator of any action(s) completed. This form and completed documentation were then to be presented to the administrator who may or may not take further action. Further, the policy directed the facility would respond to formal grievances "as soon as possible" but not longer than seven (7) days. R1's quarterly Minimum Data Set (MDS) dated 6/24/21, indicated R1 had moderate cognitive impairment and required extensive assistance for bed mobility and transfer. Further, the MDS	F 585	F585 1) Corrective action for resident identified in deficiency A follow up meeting was scheduled on 8.2.21 due to family unable to attend quarterly care conference on 7.1.21. R1 (resident) and FM-A (spouse) met with RN Case Manager and Social Worker to discuss care and service. FM-A verbally expressed that R1 had indicated a rougher transfer during a singular event. Per care plan and RN confirmation 2 staff members do assist with all EZ stand transfers and with turning and repositioning. When Country Manor staff asked clarifying questions R1 stated I don□t think he was trying to hurt me, he is a big strong guy and maybe did not know his own strength and maybe going a bit too fast. When trying to identify the 2 staff in the room R1 could only identify one staff as a big black man and unable to provide any identifying characteristics of second staff member. R1 was unable to recall time of year or specify when this happened. Facility staff unable to establish second nurse aide in the room as R1 was unable to identify when this occurred. R1 determined there was no abuse or intent to harm and there was no harm. R1 and FM-A did not state to RN-1 or SW-A that they did not want NA-A assisting with cares. Those in attendance understood there to be resolution during	

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F 585	Continued From page 4 recorded R1 as having depression and demonstrating no pain. R1's care plan, dated 8/02/12, identified R1 needed extensive assist of two with turning and repositioning and transferred with assistance of two with a EZ stand (mechanical device to transfer). On 9/9/21, at 9:47 a.m. R1 was observed seated in his wheelchair in his room with oxygen on. R1 was interviewed at this time, and he explained he had just recently moved to his current room from the Pinecone Unit. However, R1 explained when he resided on the Pinecone Unit there had been a "big black man" who was rough when he transferred him into bed. R1 described it, "He would just plop me in bed and it hurt so bad when he would turn me!" R1 expressed he reported these concerns about the man to his family member (FM)-A several times, who then reported it to a nurse which resulted in a meeting being held between FM-A and the facility to discuss the concerns. R1 reiterated he did not like or want the man providing care to him because of the way he interacted with him in the past. In a additional interview at 9:55 a.m. R1 did state he felt the "man really did not mean to hurt me and maybe did not know his own strength." In addition, R1 stated he did not feel he was abused. On 9/9/21, at 10:50 a.m. FM-A was interviewed. FM-A explained R1 had contacted her several times back in July 2021 and was upset with the way a male staff member, who R1 described as a "bigger black male," was transferring him into bed and repositioning him. These repeatedly voiced concerns caused her to ask for a meeting with the facility on 8/2/21. At the meeting, FM-A	F 585	the meeting and it was deemed a successful exchange of communication. RN Case Manager stated she would follow up with staff. In addition RN Case Manager, DON, and Rapid Recovery Clinical Director interviewed other residents regarding services and cares to determine if they had a similar experience and non were identified. DON and Director of Social Services had interactions with FM-A and/or R1 at a minimum of once a week with no reference to above mentioned alleged event. Before 8.2.21 R1 did not relay this event to staff. Upon further interview the staff were not aware of any issues with nurse aides or any lodged complaints or concerns R1 had regarding an individual staff. Subsequent conversations with DON, Director of Social Services and Rapid Recovery Clinical Director report that neither FM-A and R1 at no time requested NA-A not provide care. NA-A was interviewed and it was communicated to NA-A and Scheduling that NA-A would not be working with R1 going forward. RN Case Manager and Social Worker were re-educated on the importance of filling out concern forms to facilitate appropriate follow up. 2) Facility will identify other residents with the potential to be affected All staff will be re-educated on facility concern intake policy and procedures. Other residents with the potential to be effected will be identified through daily interactions. 3) Measures and systemic changes made to ensure deficient practice will not recur:	

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F 585	Continued From page 5 provided the registered nurse manager (RN)-A and social worker (SW)-A with a list of her concerns including R1's concerns about potentially rough transfers and repositioning by this male staff member. FM-A expressed frustration with the facility's lack of follow-up to the concern and added, "I had to provide my issues in writing [to them] since I felt this was the only way they would respond to my concerns since I had so many [concerns] in the past with no response." During subsequent interview with FM-A, at 11:26 a.m., FM-A reiterated RN-A and SW-A attended the meeting on 8/2/21, and she voiced she no longer wanted the male staff member to work with R1. FM-A added, "I honestly thought the worker quit since I [hadn't] seen him but no one got back me about this at all. I don't even know if he has worked with [R1] after I made my complaint." A requested list of grievances from the facility for R1 indicated the following: On 8/30/21, a Concern Tracking Form was made that indicated FM-A had concerns on care areas including 1. O2 tubing and placement-alleges on the floor. 2. Use of mechanical lift device for mobility (EZ stand to EZ Lift) 3. Missing T-shirts 4. Missing sock for brace x1 and did report she "had to move" resident to room due to closure of unit. The concern form did not indicate any concern of rough transfers of cares for R1. When interviewed on 9/9/21, at 1:40 p.m. RN-A recalled and verified she had been made aware of concerns with potentially rough cares and transfers by a male staff member from R1 and FM-A at a meeting with them on 8/2/21. RN-A explained they were able to identify the staff member as nursing assistant (NA)-A, and NA-A	F 585	Mandatory training for all staff will be conducted and will include re-education on facility concern intake policies and procedures. Residents with the potential to be effected will be identified through daily interactions. When concerns are identified, facility protocols will be implemented. A stratified facility audit will be completed weekly on 5 residents for 1 month. Then audits will be conducted on a routine basis to ensure continued compliance. On-going staff mentoring will be conducted as necessary. 4) The facilities plan to monitor performance, measure effectiveness and integrate into quality assurance program: The facility will assure continued compliance by conducting weekly audits for 1 month. Then audits will be conducted on a routine basis and monitored through the Quality Assurance Process. If issues are identified, facilities policies and procedures will be reviewed and appropriate interventions will be implemented. Director of Quality and DON are responsible for correction, monitoring effectiveness and implementing interventions. Timeline for correction October 4, 2021	

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F 585	Continued From page 6	F 585		

had typically been regarded as a good NA and did not suspect NA acted willfully to harm to injure R1 while caring for him. RN-A stated she spoke with R1 about the concern, and she felt him to be "kind of wavering" in his story and concern; however, RN-A verified he did report potential concerns with rough transfers and treatment. RN-A expressed a grievance should have been completed for R1 and FM-A's concern(s) and added she believed SW-A did this and completed any needed follow-up to ensure it was resolved.

R1's medical record was reviewed and lacked evidence the voiced grievance and concern about potentially rough cares was documented, acted upon or resolved through means in accordance with their policy and procedures for grievances.

During interview on 9/9/21, at 2:02 p.m. the director of nursing (DON) stated she was aware R1 had expressed concerns of potentially rough treatment by NA-A; however, she had not been informed by RN-A or SW-A that the concern involved rough transfers. The only incident or concern she had knowledge of resulted from visiting with R1 on 8/10/21, when R1 had voiced NA-A put socks on his (R1's) feet which caused his feet to hurt. A provided document, dated 8/10/21, indicated the DON visited with R1 who voiced, "It was a weekend, did not know time of the year. He had surgery on his feet in the 50's and the black man pulled on his socks too fast and caused pain in his feet. He was not able to specify when this happened. He had not worked with [R1] since this incident, he did not mention abuse or mistreatment, only that his feet hurt when the man pulled on his socks."

When interviewed on 9/9/21, at 3:11 p.m. SW-A

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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) COMPLETION DATE
F 585	Continued From page 7 stated she recalled being present at the meeting held with R1 and FM-A on 8/2/21, and she verified FM-A expressed concerns about rough treatment adding R1 voiced the male staff member "probably just didn't know his own strength." SW-A stated she did not recall who the specific staff member was, nor any subsequent actions taken to address the concern adding the nurse manager (RN-A) no longer worked at the nursing home. During interview 9/9/21, at 3/15/21 p.m. she felt there was no reason to fill out a grievance/concern tracking form since SW-A addressed the issues at the meeting they had on 8/2/2021.	F 585		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 29, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: I29B11

Dear Administrator:

The above facility was surveyed on September 9, 2021 through September 9, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00627	A. BUILDING: _____ B. WING _____	C 09/09/2021

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COUNTRY MANOR HEALTH & REHAB CTR	**520 FIRST STREET NORTHEAST SARTELL, MN 56377**

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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 9/9/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5330057C (MN76345) with licensing orders issued at 1880 The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall	21880		10/4/21

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21880	Continued From page 2 have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure voiced concerns about care were acted upon, assessed, and resolved to satisfaction for 1 of 1 resident (R1) who had complaints of rough treatment during transfers in and out of bed. Findings include: A provided Formal Grievances policy, undated, identified the facility recognized grievances may arise from residents and their families, and it listed an intent of dealing with such concerns effectively so all such situations could be addressed and resolved. The policy directed any grievance was to be brought to the department manager, or designee, and/or the Vice President	21880	Corrected	

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21880	Continued From page 3	21880		

of long-term care (LTC) and RR/AC. If unable to be resolved at that time, then the appropriate department supervisor was to be notified and a Country Manor Concern Intake Form completed with the nature of the grievance(s), any action(s) taken, and the initiator of any action(s) completed. This form and completed documentation were then to be presented to the administrator who may or may not take further action. Further, the policy directed the facility would respond to formal grievances "as soon as possible" but not longer than seven (7) days.

R1's quarterly Minimum Data Set (MDS) dated 6/24/21, indicated R1 had moderate cognitive impairment and required extensive assistance for bed mobility and transfer. Further, the MDS recorded R1 as having depression and demonstrating no pain.

R1's care plan, dated 8/02/12, identified R1 needed extensive assist of two with turning and repositioning and transferred with assistance of two with a EZ stand (mechanical device to transfer).

On 9/9/21, at 9:47 a.m. R1 was observed seated in his wheelchair in his room with oxygen on. R1 was interviewed at this time, and he explained he had just recently moved to his current room from the Pinecone Unit. However, R1 explained when he resided on the Pinecone Unit there had been a "big black man" who was rough when he transferred him into bed. R1 described it, "He would just plop me in bed and it hurt so bad when he would turn me!" R1 expressed he reported these concerns about the man to his family member (FM)-A several times, who then reported it to a nurse which resulted in a meeting being held between FM-A and the facility to discuss the

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concerns. R1 reiterated he did not like or want the man providing care to him because of the way he interacted with him in the past. In a additional interview at 9:55 a.m. R1 did state he felt the "man really did not mean to hurt me and maybe did not know his own strength." In addition, R1 stated he did not feel he was abused.

On 9/9/21, at 10:50 a.m. FM-A was interviewed. FM-A explained R1 had contacted her several times back in July 2021 and was upset with the way a male staff member, who R1 described as a "bigger black male," was transferring him into bed and repositioning him. These repeatedly voiced concerns caused her to ask for a meeting with the facility on 8/2/21. At the meeting, FM-A provided the registered nurse manager (RN)-A and social worker (SW)-A with a list of her concerns including R1's concerns about potentially rough transfers and repositioning by this male staff member. FM-A expressed frustration with the facility's lack of follow-up to the concern and added, "I had to provide my issues in writing [to them] since I felt this was the only way they would respond to my concerns since I had so many [concerns] in the past with no response." During subsequent interview with FM-A, at 11:26 a.m., FM-A reiterated RN-A and SW-A attended the meeting on 8/2/21, and she voiced she no longer wanted the male staff member to work with R1. FM-A added, "I honestly thought the worker quit since I [hadn't] seen him but no one got back me about this at all. I don't even know if he has worked with [R1] after I made my complaint."

A requested list of grievances from the facility for R1 indicated the following:
On 8/30/21, a Concern Tracking Form was made that indicated FM-A had concerns on care areas

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including 1. O2 tubing and placement-alleges on the floor. 2. Use of mechanical lift device for mobility (EZ stand to EZ Lift) 3. Missing T-shirts 4. Missing sock for brace x1 and did report she "had to move" resident to room due to closure of unit. The concern form did not indicate any concern of rough transfers of cares for R1.

When interviewed on 9/9/21, at 1:40 p.m. RN-A recalled and verified she had been made aware of concerns with potentially rough cares and transfers by a male staff member from R1 and FM-A at a meeting with them on 8/2/21. RN-A explained they were able to identify the staff member as nursing assistant (NA)-A, and NA-A had typically been regarded as a good NA and did not suspect NA acted willfully to harm to injure R1 while caring for him. RN-A stated she spoke with R1 about the concern, and she felt him to be "kind of wavering" in his story and concern; however, RN-A verified he did report potential concerns with rough transfers and treatment. RN-A expressed a grievance should have been completed for R1 and FM-A's concern(s) and added she believed SW-A did this and completed any needed follow-up to ensure it was resolved.

R1's medical record was reviewed and lacked evidence the voiced grievance and concern about potentially rough cares was documented, acted upon or resolved through means in accordance with their policy and procedures for grievances.

During interview on 9/9/21, at 2:02 p.m. the director of nursing (DON) stated she was aware R1 had expressed concerns of potentially rough treatment by NA-A; however, she had not been informed by RN-A or SW-A that the concern involved rough transfers. The only incident or concern she had knowledge of resulted from

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21880	Continued From page 6 visiting with R1 on 8/10/21, when R1 had voiced NA-A put socks on his (R1's) feet which caused his feet to hurt. A provided document, dated 8/10/21, indicated the DON visited with R1 who voiced, "It was a weekend, did not know time of the year. He had surgery on his feet in the 50's and the black man pulled on his socks too fast and caused pain in his feet. He was not able to specify when this happened. He had not worked with [R1] since this incident, he did not mention abuse or mistreatment, only that his feet hurt when the man pulled on his socks." When interviewed on 9/9/21, at 3:11 p.m. SW-A stated she recalled being present at the meeting held with R1 and FM-A on 8/2/21, and she verified FM-A expressed concerns about rough treatment adding R1 voiced the male staff member "probably just didn't know his own strength." SW-A stated she did not recall who the specific staff member was, nor any subsequent actions taken to address the concern adding the nurse manager (RN-A) no longer worked at the nursing home. During interview 9/9/21, at 3/15/21 p.m. she felt there was no reason to fill out a grievance/concern tracking form since SW-A addressed the issues at the meeting they had on 8/2/2021. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to ensure residents complaints and grievances are being addressed promptly. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) complaints and grievances are addressed on a timely basis. The results of these	21880		

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21880	Continued From page 7 audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21880		