Electronically delivered
November 19, 2021

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

RE: CCN: 245550
Cycle Start Date: November 5, 2021

Dear Administrator:

On November 5, 2021, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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" 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 February 5, 2022 (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 May 5, 2022 (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.

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
	245550	A. BUILDING _____ B. WING _____	C 11/05/2021

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 11/4/21 through 11/5/21, an abbreviated standard survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: however, no deficiencies were cited due to action taken by the facility prior to survey H5550024C (MN76973) H5550025C (MN75730) The following complaints were found to be unsubstantiated: H5550023C (MN78191) As a result of the investigation related deficiencies were cited at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		12/6/21

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

Electronically Signed | 11/29/2021

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

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F 609	Continued From page 1 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of abuse was immediately reported to the State Agency (SA) for 1 of 3 residents (R1) reviewed for potential abuse. Findings include: R1's quarterly minimum data set (MDS) dated	F 609	1. Corrective Action for the residents found to have been affected by the alleged deficient practice: • Report was made to State Agency on 11/2/2021. 2. Other residents identified as having potential to be affected by the same alleged deficient practice: • Though there is potential for all	

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F 609	Continued From page 2 9/10/21, identified R1 was cognitively intact and required supervision with transfers and toileting. Diagnoses included stroke and congestive heart failure. The Nursing Home Incident Reporting- Incident Report Summary 244751 submitted to the SA on 11/2/21, at 12:58 p.m. identified an allegation of potential staff to resident physical abuse with potential for emotional or mental abuse. The report identified the date and time of the incident as 11/1/21, at 4:00 a.m.; however, the incident description identified R1's family member (FM-A) reported the allegation to the director of nursing (DON) on 10/28/21. Further, The facility internal investigation notes dated 10/26/21, identified the director of nursing (DON) received an e-mail from FM-A regarding a concern of alleged staff to resident abuse during cares. The DON replied to FM-A on 10/26/21, and indicated the facility would investigate the concern. The DON forwarded the e-mail chain to social worker designee (SS)-A on 10/26/21. During interview on 11/5/21, at 12:58 p.m. the DON stated the DON, administrator and SS-A met and discussed the concern and decided SS-A would submit the report to the SA. The next morning the DON searched the reported incident and could not find it. The DON stated SS-A thought she had 24 hours to report the incident and didn't think it needed to be reported immediately. The DON stated R1's alleged abuse should have been reported immediately The Reporting of Mistreatment of Vulnerable Adults policy revised 4/8/21, identified all residents had the right to be free from abuse. If	F 609	residents to be affected by the alleged deficient practice, no negative outcomes have been identified at this time • DON reviewed all resident progress notes and risk management reports for any potential non-reported reportable incidents for the 60 day period preceding the alleged deficient practice. 3. Measures put into place/changes made to ensure the alleged deficient practice will not recur: • Vulnerable Adult Reporting policy was reviewed and revised to clarify and improve the process • Vulnerable Adult Reporting checklist was reviewed and revised to clarify and improve the process • Provided face-to-face/video education to Internal Designated Reporters regarding the updated policy, procedure and checklist • Provided updated policy to all staff for review, with a follow-up quiz. Employees receiving less than 100% accuracy will be re-educated by Staff Development Coordinator and required to re-test. • Provided direct education to individuals involved in the alleged deficient practice • Education will be provided to employees at the all employee meeting on 12/6/2021 regarding professionalism, dignity and respect. • Social worker will provide information to NSM residents during the next resident council meeting. 4. How the facility will monitor its corrective actions to ensure the alleged deficient practice will not recur:	

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F 609	Continued From page 3 an employee has knowledge of potential abuse it would be reported immediatly to their supervisor, who would then report to the administrator. "Immediately: means as soon as possible, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury."	F 609	• Director of Nursing or designee will review resident medical records, risk management, and stop and watch reports five days per week, to ensure all reportable incidents are reported and reported timely. All abnormal findings will be reported to IDT. Weekly audits will be completed until 100% compliance is met and sustained for 90 days.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse were thoroughly investigated to prevent further or ongoing abuse for 1 of 3 residents (R1) reviewed for potential abuse.	F 610	1. Corrective Action for the residents found to have been affected by the alleged deficient practice: • Social Worker interviewed the resident on 11/1/2021 and 11/2/2021for	12/6/21

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F 610	Continued From page 4 Findings include: R1's quarterly minimum data set (MDS) dated 9/10/21, identified R1 was cognitively intact and required supervision with transferring and toileting. Diagnoses include stroke and congestive heart failure. The Nursing Home Incident Reporting-Investigation Report Summary 44211- submitted to the State Agency on 11/9/21, identified the facility reviewed the facility vulnerable adult reporting policy, staff interviews and progress notes as part of the investigation. The facility ended the contract with nursing assistant (NA)-A as it was determined NA-A was rough while removing R'1 Ted hose. The report did not identify if any other residents were interviewed regarding potential abuse from staff, to ensure no other residents were affected. The facilities internal investigation notes did not identify any other residents were interviewed about potential abuse. During interview on 11/5/21, at 12:58 p.m. the DON stated an abuse investigation would include interviewing the alleged perpetrator, the residents involved and other staff as needed. The facility did not interview other residents regarding potential abuse. The facility policy Reporting of Mistreatment of Vulnerable Adults revised 4/8/21, identified a checklist that included an internal investigation which would include staff/resident interviews, and would be reviewed with director of nursing and Administrator, summarized and submitted to the	F 610	possible adverse effects resulting from the alleged violation. No adverse effects have been identified. 2. Other residents identified as having potential to be affected by the same alleged deficient practice: • Though there is potential for all residents to be affected by the alleged deficient practice, facility Social Worker interviewed other residents and no negative outcomes have been identified at this time. 3. Measures put into place/changes made to ensure the alleged deficient practice will not recur: • The Vulnerable Adult Reporting checklist was reviewed and revised to include a cue to initiate additional interviews with other residents when appropriate • Provided direct education to individuals involved in the investigation process • Social Worker and Administrator developed an investigation checklist to ensure no steps in the internal investigation are missed. • Social worker will provide information to NSM residents during the next resident council meeting. 4. How the facility will monitor its corrective actions to ensure the alleged deficient practice will not recur: • Facility Administrator or designee will review all internal investigations prior to submission and conduct weekly audits of the internal investigation checklists for three months.	

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F 610	Continued From page 5 SA by social services designee within five working days. The policy did not direct how the facility would conduct an internal investigation.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 19, 2021

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

Re: Event ID: OI4111

Dear Administrator:

The above facility survey was completed on November 5, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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
	00356	A. BUILDING: _____ B. WING _____	C 11/05/2021

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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 11/4/21 through 11/5/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be not in compliance with the MN State licensure. The following complaints were found to be substantiated; however, no licensing orders were	2 000		

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2 000	Continued From page 1 issued. H5550024C (MN76973) H5550025C (MN75730) The following complaint was found to be unsubstantiated: H5550023C (MN78191) The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of starte form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		