DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 27, 2022

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

RE: CCN: 245550
Cycle Start Date: May 24, 2022

Dear Administrator:

On June 17, 2022, we informed you that we may impose enforcement remedies.

On June 16, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 25, 2022

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 25, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 25, 2022.

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.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 25, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, North Star Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 25, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an E 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 November 25, 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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (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, Compliance Analyst
Minnesota Department of Health
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 06/16/2022

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 6/15/22- 6/16/22, 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 complaint was found to be UNSUBSTANTIATED: H55502097C (MN00084142) The following complaint was found to be SUBSTANTIATED: H55502376C (MN00083839), with no deficiency cited because the provider had implemented corrective action prior to survey. However, based on the investigations, a deficiency will be 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	F 585		7/15/22

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

Electronically Signed | 07/01/2022

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 585	Continued From page 1 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 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	F 585		

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F 585	Continued From page 2 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 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	F 585		

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F 585	Continued From page 3 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 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 grievances concerning call lights were addressed and resolved to satisfaction for 2 of 2 residents (R1 and R3) who reported dissatisfaction with extended wait times for call lights to be answered or call light access. Findings include: R1's Admission Record indicated a diagnosis of late onset Alzheimer's Disease and Anxiety Disorder. On 6/15/22, at 11:41 am. R1 was observed seated in a wheelchair in her room. R1 was not utilizing oxygen, however, there was an oxygen concentrator in the corner of the room. R1 stated she did not need to use oxygen all of the time, only when she was short of breath. R1 stated when she felt short of breath, she felt anxious "like I will pass out." When queried if the staff members answered her call light timely, R1 stated call light response time was dependent upon which staff members were working. Sometimes the staff would respond timely, other times it would take a long time. R1 did not define	F 585	F585 – Grievances 1. How corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice: • Policy and procedures have been updated and reviewed. New documentation to be completed that will follow new updated policy and procedure for residents found to have been affected by alleged deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: • Concerns or grievances are a standing daily IDT agenda item. DON will audit IDT notes from the previous 3 months, to identify other residents that may have been affected by the same alleged deficient practice. 3. Measures put into place/changes made to ensure the alleged deficient practice will not recur: • 1:1 education provided to the facility Social Worker regarding her specific role in the grievance/concern process.	

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F 585	Continued From page 4 "a long time." R1's Medication Administration Record (MAR) dated 6/2022, directed the staff to administer oxygen via nasal cannula at 2 liters per minute as needed for oxygen saturation less than 92%. R1's Progress Note (nurses note) dated 6/5/22, (**note FM-A reported the concern occurred on 6/4/22, however documentation identified the incident occurred on 6/5/22) indicated R1 had expressed concerns of shortness of breath. R1's oxygen saturation was 85% and the staff members had applied oxygen via nasal cannula. R1's oxygen saturation increased to 97% after 15 minutes. On 6/15/22, at 11:04 a.m. FM-A stated on 6/4/22, R1 was short of breath and the facility did not respond to her call light timely. FM-A stated the facility did not have enough staff to care for the residents and that was affecting their ability to answer call lights. FM-A stated he had attempted to talk to the facility staff members about his concerns but did not feel they had addressed his concern. On 6/15/22, at 4:42 p.m. the director of nurses (DON) stated the morning of 6/9/22, she had been notified FM-A had expressed a concern related to timely call light response to an unidentified facility staff member on the evening of 6/8/22. The DON stated the facility was actively conducting an internal investigation. The DON stated the licensed social worker (LSW-A) should follow up with FM-A. The DON confirmed she had not discussed the concern with FM-A. R3's Admission Record indicated a diagnosis of	F 585	• Education to all staff regarding the Grievance/Concern policy • Updated Grievance/Concern Policy and Form • Ombudsman for LTC will attend next Resident Council meeting to review Residents Rights related to grievances with the Residents. • We will continue to go over Grievances/Concerns in daily IDT meeting, with a prompt to initiate Grievance/Concern form when indicated. 4. How the facility will monitor its corrective actions to ensure the alleged deficient practice is being corrected and will not recur: • Audits will be completed on every Grievance/Concern that is received by Administrator or designee for the next 4 months and ongoing as needed to ensure facility policy has been followed and all documentation is in place.	

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F 585	Continued From page 5 chronic obstructive pulmonary disease, unspecified dementia without behaviors, anxiety, major depressive disorder and blindness right eye, cataract to the left. R3's Care Area Assessment (CAA) dated 7/21 revealed self-care performance deficit related to blindness in both eyes, weakness, and mobility impairment. On 6/15/22, at 2:30 p.m. R3 was observed seated in a recliner in her room with oxygen on. R3 was a blind alert resident. R3 stated the staff members did not always respond to her call light timely and sometimes she was unable to reach her call light. R3 stated she needed to have her call light because she could not see things around her and needed assistance to find items she wanted. At 2:45 p.m. FM-B entered R3's room. FM-B stated he visited the facility 1-2 times per week and in a span of two weeks, he had found R3 without a call light within her reach. FM-B stated he had talked to the DON regarding his concern about R3 not being able to reach her call light. FM-B had informed the facility he was going to report the facility to the State Agency. FM-B stated the DON had informed him; she would report the concern to the State Agency. FM-B stated he had not had any further conversations with the facility regarding R3 not being able to reach her call light and was unaware of any action taken by the facility to resolve his concerns. Review of a Nursing Home Incident Report (NHIR) dated 5/26/22, revealed the facility had reported R3 was in her room for 46 minutes	F 585		

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F 585	Continued From page 6 without her call light within reach on 5/26/22. R3's progress note dated 5/26/22, at 5:40 p.m. indicated FM-B had expressed concern to the facility related to R3 not having an accessible call light. R3's progress noted dated 5/26/22, at 6:15 p.m. indicated the DON had informed FM-B a report had been submitted to the State Agency. R3's progress notes from 5/2722 - 6/16/22 lacked further documentation related to the concern related to call light access or follow up with FM-B. On 6/15/22, at 3:10 p.m. LSW-A stated the facility had reviewed the hallway video surveillance and had identified the staff member responsible for R3 on 5/26/22. They had provided education to all staff members on the importance of ensuring call lights were within reach for all residents who were able to use them and completed call light audits to ensure compliance with call light response. When asked if LSW-A had followed up with the family member who had expressed the concern, LSW-A stated she was unaware of who FM-B was and therefore had not followed up with him. The facility Grievance Policy dated 5/23/22, indicated all residents receiving services at the facility had the right to voice grievances to the facilities grievance officer without fear of discrimination or reprisal. The policy identified the facility grievance officer by name as LSW-A. Any grievance could be submitted verbally or in writing. The policy directed the grievance officer to:	F 585		

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F 585	Continued From page 7 - Be responsible for overseeing the grievance process. -Receive and track grievances through to their conclusion. -Lead any necessary investigation by the facility. -Maintain the confidentiality of all information associated with the grievance. -Issue written grievances decisions to the resident. -Coordinate with the State and federal agencies as necessary in light of specific allegation; and as necessary, taking immediate action to prevent further potential violation of any resident right while the alleged violation was investigation. -Investigation of the grievance were to be started 72 hours after the grievance was filled. -Grievance will be documented on the Grievance Report. -Grievance Reports were to be reviewed by the administrator before it is provided to the complainant. -Within 10 days of filing of the grievances, the final findings were to be provided to the complainant in writing, including the method of complaint resolution and/or plan of action. The results of the finding of the investigation were to be reviewed with the complaint in person by request. On 6/15/22, at 4:27 p.m. LSW-A stated she had been at the facility for five months and the facility had not received any type of formal grievances. LSW-A confirmed FM-B's concern regarding R3's call light being with reach was a complaint. The facility had submitted the concern to the State Agency and a follow up report had been submitted within 5 days which identified the facility had responded to the complaint by providing education to the staff and completion of	F 585		

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F 585	Continued From page 8	F 585		

call light audits. LSW-A reviewed the facility grievance policy and stated she was unaware of her responsibly follow up with the complainant and to maintain documentation.

At 5:10 p.m. nursing assistant (NA)-D stated if a family member or a resident had a concern, she would report the concern to the charge nurse. The nurses were then to take care of the concern.

At 5:21 p.m. licensed practical nurse (LPN)-C stated if a resident or family member had a concern, she would try to resolve the concern on her own. If it was a concern for a different department, she would notify the appropriate department. If she was not able to resolve the concern, she would notify the DON or administrator.

At 5:30 p.m. NA-B stated any concerns expressed by a resident or family member would be reported to the charge nurse or the DON.

On 6/16/22 at 7:15 a.m. LPN-B stated if a resident or a family member expressed a concern, she would direct them to report the concern to the facility administrator.

At 7:23 a.m. registered nurse (RN)-A stated if a resident or family member expressed a concern, she would report the concern to the administrator or the DON.

At 8:48 a.m. the administrator stated any concern/grievance identified by a resident or family member could be reported to the facility either verbally or in writing. The facility staff were then to investigate and process the concern until

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 06/16/2022

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 585	Continued From page 9 an acceptable resolution could be reached to satisfy both the complainant and the facility. LSW-A was to lead the investigations and ensure the facility had a system for tracking and documenting all grievances. The administrator confirmed FM-A had expressed multiple concerns over the past few years and she was aware of FM-B's concern due to call lights. The administrator stated she had reviewed the facility video surveillance for 6/4/22 and 6/5/22. R1's call light had been one for one minute not 30 minutes as reported. R3's concern related to not having her call light within reach had been reported to the State Agency. However, she was unaware the facility did not have a current system to track and document the grievances brought forward by residents or family members. She was also unaware the facility staff had not been following up with the complainants after a grievance had been expressed as directed by the facility policy.	F 585		

Electronically delivered
June 27, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: FXTI11

Dear Administrator:

The above facility was surveyed on June 15, 2022 through June 16, 2022 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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
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 06/16/2022

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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 6/15/22- 6/16/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H55502097C (MN00084142) The following complaint was found to be SUBSTANTIATED: H55502376C (MN00083839), with no order cited because the provider had implemented corrective action prior to survey. However, based on the investigations, an order will be cited at 1800. 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 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 surveyor ' s 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 14-01, available at <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	2 000		

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2 000	Continued From page 2 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. 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.	2 000		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available	21800		7/15/22

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21800	Continued From page 3 to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: R1's Admission Record indicated a diagnosis of late onset Alzheimer's Disease and Anxiety Disorder. On 6/15/22, at 11:41 am. R1 was observed seated in a wheelchair in her room. R1 was not utilizing oxygen, however, there was an oxygen concentrator in the corner of the room. R1 stated she did not need to use oxygen all of the time, only when she was short of breath. R1 stated when she felt short of breath, she felt anxious "like I will pass out." When queried if the staff members answered her call light timely, R1 stated call light response time was dependent upon which staff members were working. Sometimes the staff would respond timely, other times it would take a long time. R1 did not define "a long time." R1's Medication Administration Record (MAR) dated 6/2022, directed the staff to administer oxygen via nasal cannula at 2 liters per minute as needed for oxygen saturation less than 92%. R1's Progress Note (nurses note) dated 6/5/22, (**note FM-A reported the concern occurred on 6/4/22, however documentation identified the incident occurred on 6/5/22) indicated R1 had expressed concerns of shortness of breath. R1's	21800	CORRECTED	

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21800	Continued From page 4 oxygen saturation was 85% and the staff members had applied oxygen via nasal cannula. R1's oxygen saturation increased to 97% after 15 minutes. On 6/15/22, at 11:04 a.m. FM-A stated on 6/4/22, R1 was short of breath and the facility did not respond to her call light timely. FM-A stated the facility did not have enough staff to care for the residents and that was affecting their ability to answer call lights. FM-A stated he had attempted to talk to the facility staff members about his concerns but did not feel they had addressed his concern. On 6/15/22, at 4:42 p.m. the director of nurses (DON) stated the morning of 6/9/22, she had been notified FM-A had expressed a concern related to timely call light response to an unidentified facility staff member on the evening of 6/8/22. The DON stated the facility was actively conducting an internal investigation. The DON stated the licensed social worker (LSW-A) should follow up with FM-A. The DON confirmed she had not discussed the concern with FM-A. R3's Admission Record indicated a diagnosis of chronic obstructive pulmonary disease, unspecified dementia without behaviors, anxiety, major depressive disorder and blindness right eye, cataract to the left. R3's Care Area Assessment (CAA) dated 7/21 revealed self-care performance deficit related to blindness in both eyes, weakness, and mobility impairment. On 6/15/22, at 2:30 p.m. R3 was observed seated in a recliner in her room with oxygen on. R3 was a blind alert resident. R3 stated the staff	21800		

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21800	Continued From page 5 members did not always respond to her call light timely and sometimes she was unable to reach her call light. R3 stated she needed to have her call light because she could not see things around her and needed assistance to find items she wanted. At 2:45 p.m. FM-B entered R3's room. FM-B stated he visited the facility 1-2 times per week and in a span of two weeks, he had found R3 without a call light within her reach. FM-B stated he had talked to the DON regarding his concern about R3 not being able to reach her call light. FM-B had informed the facility he was going to report the facility to the State Agency. FM-B stated the DON had informed him; she would report the concern to the State Agency. FM-B stated he had not had any further conversations with the facility regarding R3 not being able to reach her call light and was unaware of any action taken by the facility to resolve his concerns. Review of a Nursing Home Incident Report (NHIR) dated 5/26/22, revealed the facility had reported R3 was in her room for 46 minutes without her call light within reach on 5/26/22. R3's progress note dated 5/26/22, at 5:40 p.m. indicated FM-B had expressed concern to the facility related to R3 not having an accessible call light. R3's progress noted dated 5/26/22, at 6:15 p.m. indicated the DON had informed FM-B a report had been submitted to the State Agency. R3's progress notes from 5/2722 - 6/16/22 lacked further documentation related to the concern related to call light access or follow up with FM-B.	21800		

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21800	Continued From page 6 On 6/15/22, at 3:10 p.m. LSW-A stated the facility had reviewed the hallway video surveillance and had identified the staff member responsible for R3 on 5/26/22. They had provided education to all staff members on the importance of ensuring call lights were within reach for all residents who were able to use them and completed call light audits to ensure compliance with call light response. When asked if LSW-A had followed up with the family member who had expressed the concern, LSW-A stated she was unaware of who FM-B was and therefore had not followed up with him. The facility Grievance Policy dated 5/23/22, indicated all residents receiving services at the facility had the right to voice grievances to the facilities grievance officer without fear of discrimination or reprisal. The policy identified the facility grievance officer by name as LSW-A. Any grievance could be submitted verbally or in writing. The policy directed the grievance officer to: - Be responsible for overseeing the grievance process. -Receive and track grievances through to their conclusion. -Lead any necessary investigation by the facility. -Maintain the confidentiality of all information associated with the grievance. -Issue written grievances decisions to the resident. -Coordinate with the State and federal agencies as necessary in light of specific allegation; and as necessary, taking immediate action to prevent further potential violation of any resident right while the alleged violation was investigation. -Investigation of the grievance were to be started	21800		

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21800	Continued From page 7 72 hours after the grievance was filled. -Grievance will be documented on the Grievance Report. -Grievance Reports were to be reviewed by the administrator before it is provided to the complainant. -Within 10 days of filing of the grievances, the final findings were to be provided to the complainant in writing, including the method of complaint resolution and/or plan of action. The results of the finding of the investigation were to be reviewed with the complaint in person by request. On 6/15/22, at 4:27 p.m. LSW-A stated she had been at the facility for five months and the facility had not received any type of formal grievances. LSW-A confirmed FM-B's concern regarding R3's call light being with reach was a complaint. The facility had submitted the concern to the State Agency and a follow up report had been submitted within 5 days which identified the facility had responded to the complaint by providing education to the staff and completion of call light audits. LSW-A reviewed the facility grievance policy and stated she was unaware of her responsibly follow up with the complainant and to maintain documentation. At 5:10 p.m. nursing assistant (NA)-D stated if a family member or a resident had a concern, she would report the concern to the charge nurse. The nurses were then to take care of the concern. At 5:21 p.m. licensed practical nurse (LPN)-C stated if a resident or family member had a concern, she would try to resolve the concern on her own. If it was a concern for a different department, she would notify the appropriate	21800		

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21800	Continued From page 8 department. If she was not able to resolve the concern, she would notify the DON or administrator. At 5:30 p.m. NA-B stated any concerns expressed by a resident or family member would be reported to the charge nurse or the DON. On 6/16/22 at 7:15 a.m. LPN-B stated if a resident or a family member expressed a concern, she would direct them to report the concern to the facility administrator. At 7:23 a.m. registered nurse (RN)-A stated if a resident or family member expressed a concern, she would report the concern to the administrator or the DON. At 8:48 a.m. the administrator stated any concern/grievance identified by a resident or family member could be reported to the facility either verbally or in writing. The facility staff were then to investigate and process the concern until an acceptable resolution could be reached to satisfy both the complainant and the facility. LSW-A was to lead the investigations and ensure the facility had a system for tracking and documenting all grievances. The administrator confirmed FM-A had expressed multiple concerns over the past few years and she was aware of FM-B's concern due to call lights. The administrator stated she had reviewed the facility video surveillance for 6/4/22 and 6/5/22. R1's call light had been one for one minute not 30 minutes as reported. R3's concern related to not having her call light within reach had been reported to the State Agency. However, she was unaware the facility did not have a current system to track and document the grievances brought forward by residents or family members. She was also	21800		

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21800	Continued From page 9 unaware the facility staff had not been following up with the complainants after a grievance had been expressed as directed by the facility policy. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the resident or family grievances. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21800		