DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 2, 2023

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

RE: CCN: 245550
Cycle Start Date: January 6, 2023

Dear Administrator:

On February 23, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 2, 2023

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

Re: Reinspection Results
Event ID: WLTB12

Dear Administrator:

On February 23, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 6, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 20, 2023

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

RE: CCN: 245550
Cycle Start Date: May 25, 2022

Dear Administrator:

On January 6, 2023, a survey was completed at your facility by the Minnesota Department of Health 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"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, 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 April 6, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 6, 2023 (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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	C 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/5/23 - 1/6/23, 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 were found to be SUBSTANTIATED: H55507189C (MN86688), with a deficiency cited at F760. The following complaints were found to be UNSUBSTANTIATED: H55507238C (MN89774), with related deficiencies cited at F550, F610. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		2/1/23

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

Electronically Signed | 01/26/2023

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

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 residents (R1) were treated with dignity and respect when a facility staff member aggressively took a cup from a	F 550	F550 Resident Rights/Exercise of Rights 1. Corrective Action for the residents found to have been affected by the	

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 residents hand, causing unintentional, minor injury and made a verbal statement to R1 causing R1 to feel bad about herself. Findings include: R1's annual Minimum Data Set dated 12/2/22, identified intact cognition. R1's care plan dated 12/15/22, identified a self care deficit related to diagnosis of hypertensive encephalopathy and a history of transient ischemic attacks. A report to the state agency (SA) dated 12/29/22, indicated an incident occurred during a conversation between a facility staff member and R1, on 12/29/22, at 5:00 p.m. regarding R1's blood pressure. R1 stated trained medication aide (TMA)-A was upset and frustrated the other day. R1 stated TMA-A was yelling at her about all of her medication changes. R1 stated TMA-A handed her medications during the interaction and R1 said she would not take the medications until her blood pressure was checked. R1 said TMA-A was "set off" and grabbed the pill cup out of her hand. The report indicated R1 showed the staff member her hand. The staff member noted a couple of scratches to R1's left pinky finger. A facility investigation report dated 1/5/23, indicated the director of nursing (DON) met with R1 regarding the concern. R1 stated she had gone to see her physician earlier in the week and he had changed her medications again. R1 said she woke up on Wednesday and had breakfast in her room as usual and sometime after breakfast she felt dizzy and had a pain up her neck. R1 stated she did not report it as she thought it would pass. R1 said TMA-A came to her room around 11:00 a.m. with a plastic medication cup. R1 told TMA-A she felt dizzy and asked if she should have her	F 550	alleged deficient practice: " Identified our deficient practice to be related the process of reassigning the alleged perpetrator verses removing them from schedule or providing direct supervision. 2. Other residents identified as having potential to be affected by the same alleged deficient practice: " No further residents identified to have potentially been affected during investigation. 3. Measures put into place/changes made to ensure the alleged deficient practice will not recur: " Updated verbiage in the Reporting of Mistreatment of Vulnerable Adults policy regarding the procedure for ensuring the safety of resident(s) from the alleged perpetrator. " Leadership team has been re-educated on the updated policy/procedure called the Reporting of Mistreatment of Vulnerable Adults. 4. How the facility will monitor its corrective actions to ensure the alleged deficient practice will not recur: " Added area to VA Reporting Checklist ensuring safety to resident(s) from the alleged perpetrator until internal investigation is finalized. " DON and administrator will make a collaborative decision regarding the alleged perpetrator's suspension/direct supervision, pending completion of the	

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 blood pressure checked before taking her pills. R1 said she thought that had upset TMA-A who asked her to take the pills first to which R1 replied "No, I don't want to take them without knowing my blood pressure." R1 stated TMA-A grabbed the cup out of her hand and said she felt a scratch on her finger at the time but did not think much of it until later. The report indicated R1 had two bruises on her fingers and a scratch. The report also indicated R1 stated as TMA-A was leaving her room she stopped in the doorway and said, "If you saw a real doctor you would have a pill that worked without all these med changes every day." During interview on 1/5/23, at 2:20 p.m. TMA-A stated, "I think this lady, I don't think she likes me." TMA-A stated she was concerned as R1 was her resident and said "the scratch, the bruising, I would never do anything like that." TMA-A stated she had long nails and indicated that may have caused the scratch unintentionally. TMA-A stated she brought the medications to R1 and she did not want to take them. TMA-A said "we were both frustrated." TMA-A said she took the cup from R1 and had another staff give the medications. TMA-A stated she did not remember saying anything about the physician except they had changed the medications again. During interview on 1/5/23, at 4:51 p.m. R1 stated she had trouble with her blood pressure and had gone to her physician quite a bit. R1 stated the day before the incident she had been to the clinic and the physician changed her medication and the time it was given. R1 stated TMA-A brought her two pills and she asked to have her blood pressure taken because she had been dizzy. R1 said she told TMA-A she was not going to take	F 550	investigation. " All VA reports will be reviewed discussed during IDT meetings to ensure all policies and producers are followed. 5. Date alleged deficiencies will be corrected: " February 1, 2023	

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 the pills without checking her blood pressure because she was afraid her blood pressure would "bottom out." R1 stated TMA-A grabbed the cup, "she ripped it out of my hand" and said she got a cut and some bruising. R1 said she wasn't going to say anything and said, "I've heard her holler before." R1 stated after TMA-A ripped the cup out of her hand she stopped in the doorway and said, "you could go to a real doctor and maybe something could get resolved" and said she had never seen anyone with medication changes so many times. R1 stated she could see TMA-A was mad and said "she had an angry look on her face." R1 stated it made her feel terrible. R1 further stated, "I do feel like I was abused by her and I am afraid of her. She will probably come and say something to me like it's my fault." On 1/6/23, at 11:54 a.m. the administrator, DON and Social worker (SW) were interviewed. The DON stated a staff member had reported to her the conversation between R1 and TMA-A. The DON said initially R1 could not recall what day it had occurred but remembered TMA-A had been upset and talking with a raised voice. The DON said she went to R1's room and met with her and R1 shared the story with her. The DON stated R1 had a pinpoint mark on her finger and said it looked like a blood blister. The DON said the underside of R1's ring finger had faint blue bruising and some faint discoloration on the middle finger. The DON stated "we feel there was a misunderstanding between [R1] and [TMA-A]. R1 "thought [TMA-A] was upset with her." The DON said "in reality [TMA-A] was worried and concerned about [R1]." The DON stated she did not feel TMA-A's behavior was appropriate and had written up an action plan and planned to review it with TMA-A. The DON further stated	F 550		

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5 TMA-A had not received any education but they planned to meet with her to present the corrective action plan and planned to have the staff development coordinator present education. At the time of survey, TMA-A had not received any education related to resident dignity and respect, resident rights or abuse training to ensure immediate correction. A facility policy Reporting Mistreatment of Vulnerable Adults dated 7/11/22, indicated all residents have the right to be free form abuse, neglect, misappropriation of property and exploitation. The policy indicated the facility will follow all state and federal regulations for abuse prevention and protection of vulnerable adults.	F 550		
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.	F 610		2/1/23

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policy to ensure adequate resident protection and a thorough investigation following an allegation of abuse for 1 of 2 residents (R1) reviewed for abuse. Findings include: R1's annual Minimum Data Set dated 12/2/22, identified intact cognition. R1's care plan dated 12/15/22, identified a self care deficit related to diagnosis of hypertensive encephalopathy and a history of transient ischemic attacks. A report to the state agency (SA) dated 12/29/22, indicated an incident occurred during a conversation between a facility staff member and R1, on 12/29/22, at 5:00 p.m. regarding R1's blood pressure. R1 stated trained medication aide (TMA)-A was upset and frustrated the other day. R1 stated TMA-A was yelling at her about all of her medication changes. R1 stated TMA-A handed her medications during the interaction and R1 said she would not take the medications until her blood pressure was checked. R1 said TMA-A was "set off" and grabbed the pill cup out of her hand. The report indicated R1 showed the staff member her hand. The staff member noted a couple of scratches to R1's left pinky finger. A facility investigation report dated 1/5/23, indicated the director of nursing (DON) met with R1 regarding the concern. R1 stated she had gone to see her physician earlier in the week and he had changed her medications again. R1 said she woke up on Wednesday and had breakfast in her room as usual and sometime after breakfast she felt dizzy and had a pain up her neck. R1 stated	F 610	F610 □ Investigate/Prevent/Correct Alleged Violation 1. Corrective Action for the residents found to have been affected by the alleged deficient practice: " Identified our deficient practice to be related the process of reassigning the alleged perpetrator verses removing them from schedule or providing direct supervision. 2. Other residents identified as having potential to be affected by the same alleged deficient practice: " No further residents identified to have potentially been affected during investigation. 3. Measures put into place/changes made to ensure the alleged deficient practice will not recur: " Updated verbiage in the Reporting of Mistreatment of Vulnerable Adults policy regarding the procedure for ensuring the safety of resident(s) from the alleged perpetrator. " Leadership team has been re-educated on the updated policy/procedure called the Reporting of Mistreatment of Vulnerable Adults. 4. How the facility will monitor its corrective actions to ensure the alleged deficient practice will not recur: " Added area to VA Reporting Checklist ensuring safety to resident(s) from the alleged perpetrator until internal	

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 7 she did not report it as she thought it would pass. R1 said TMA-A came to her room around 11:00 a.m. with a plastic medication cup. R1 told TMA-A she felt dizzy and asked if she should have her blood pressure checked before taking her pills. R1 said she thought that had upset TMA-A who asked her to take the pills first to which R1 replied "No, I don't want to take them without knowing my blood pressure." R1 stated TMA-A grabbed the cup out of her hand and said she felt a scratch on her finger at the time but did not think much of it until later. The report indicated R1 had two bruises on her fingers and a scratch. The report also indicated R1 stated as TMA-A was leaving her room she stopped in the doorway and said, "If you saw a real doctor you would have a pill that worked without all these med changes every day." The report indicated R1 had two bruises on her fingers and a scratch. During interview on 1/5/23, at 2:20 p.m. TMA-A stated, "I think this lady, I don't think she likes me." TMA-A stated she was concerned as R1 was her resident and said "the scratch, the bruising, I would never do anything like that." TMA-A stated she had long nails and indicated that may have caused the scratch. TMA-A stated she brought the medications to R1 and she did not want to take them. TMA-A said "we were both frustrated." TMA-A said she took the cup from R1 and had another staff give the medications. TMA-A stated she did not remember saying anything about the physician except they had changed the medications again. TMA-A stated after the incident she had worked with R1 the next day then was moved to the other unit. TMA-A stated the Friday after was her day off and said she got a phone call and was told she could not work on R1's wing and could not be around	F 610	investigation is finalized. " DON and administrator will make a collaborative decision regarding the alleged perpetrator's suspension/direct supervision, pending completion of the investigation. 5. Date alleged deficiencies will be corrected: " February 1, 2023	

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 8	F 610		

her but she continued to work with other residents.

During interview on 1/5/23, at 4:51 p.m. R1 stated she had trouble with her blood pressure and had gone to her physician quite a bit. R1 stated the day before the incident she had been to the clinic and the physician changed her medication and the time it was given. R1 stated TMA-A brought her two pills and she asked to have her blood pressure taken because she had been dizzy. R1 said she told TMA-A she was not going to take the pills without checking her blood pressure because she was afraid her blood pressure would "bottom out." R1 stated TMA-A grabbed the cup, "she ripped it out of my hand" and said she got a cut and some bruising. R1 said she wasn't going to say anything and said, "I've heard her holler before." R1 stated after TMA-A ripped the cup out of her hand she stopped in the doorway and said, "you could go to a real doctor and maybe something could get resolved" and said she had never seen anyone with medication changes so many times. R1 stated she could see TMA-A was mad and said "she had an angry look on her face." R1 stated it made her feel terrible. R1 further stated, "I do feel like I was abused by her and I am afraid of her. She will probably come and say something to me like it's my fault."

On 1/6/23, at 11:54 a.m. the administrator, DON and Social worker (SW) were interviewed. The DON stated a staff member had reported to her the conversation between R1 and TMA-A. The DON said initially R1 could not recall what day it had occurred but remembered TMA-A had been upset and talking with a raised voice. The DON said she went to R1's room and met with her and R1 shared the allegation with her. The DON

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 9 stated R1 had a pinpoint mark on her finger and said it looked like a blood blister. The DON said the underside of R1's ring finger had faint blue bruising and some faint discoloration on the middle finger. The DON stated "we feel there was a misunderstanding between [R1] and [TMA-A]. R1 "thought [TMA-A] was upset with her." The DON said "in reality [TMA-A] was worried and concerned about [R1]." The DON stated she did not feel TMA-A's behavior was appropriate and had written up an action plan to review with TMA-A, however, this had not been done yet. The DON stated she felt part of the problem was R1 and TMA-A had known each other for so long they treated each other more as friends instead of a professional relationship. The DON stated when she spoke with R1 she proposed they move TMA-A to the other unit. When asked if other residents had been interviewed for potential concerns the DON sated they had not talked to any other residents because they felt it was an isolated incident and did not feel other residents would have been harmed or affected. The DON said they had a conversation with TMA-A prior to her next shift but said she did not go into all the details. The DON said TMA-A was told she could not go to the east unit where R1 resided and could not have any interaction with R1. The DON said the hug in the dining room was brought to their attention the following Monday and she and the administrator had a conversation with TMA-A to discuss. The DON further stated TMA-A had not received any education but they planned to meet with her to present the corrective action plan and planned to have the staff development coordinator present education. The SW stated the immediate interventions was to not have TMA-A work with R1 and said R1 and her family was comfortable with that. The DON stated "we	F 610		

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 10 truly did not feel suspension of [TMA-A] was warranted because we did not feel the other residents were at risk. A facility policy Reporting Mistreatment of Vulnerable Adults dated 7/11/22, indicated all residents have the right to be free form abuse, neglect, misappropriation of property and exploitation. The policy indicated the facility will follow all state and federal regulations for abuse prevention and protection of vulnerable adults. The policy further indicated for reports made alleging a facility employee as a perpetrator, appropriate action will be taken to protect the resident, up to and including removing the employee from the schedule pending the results of the internal investigation.	F 610		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 3 residents (R3) reviewed remained free from a significant medication error when Lorazepam (class of drugs known as benzodiazepines which act on the brain and nerves) was administered to R3 eight times the prescribed dose. Findings include: R3's quarterly Minimum Data Set identified severe cognitive impairment and indicated dependence on staff to complete activities of daily	F 760	F760- The facility must ensure that its residents are free of any significant medication errors. 1. Corrective Action for the residents found to have been affected by the alleged deficient practice: " The DON interviewed the staff involved in the medication error on 12/28/2022. During interview it was identified that a medication was dispensed without a written order. 2. Other residents identified as having	2/1/23

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 11 living. R3's care plan dated 12/28/22, identified a risk for pain and directed staff to administer medications as prescribed. R3's physician Order Summary Report dated 12/27/22, indicated Lorazepam oral tablet 0.5 mg. Place and dissolve 0.5 mg buccaly (in or near the cheek area) every four hours as needed for anxiety/restlessness and Lorazepam oral tablet 0.5 mg. Place and dissolve 0.5 mg buccaly every four hours for anxiety/restlessness. R3's Individual Narcotic Record indicated name of drug and dose: Lorazepam 0.5 mg. The record indicated on 12/27/22, at 8:54 a.m. LPN-A administered 1 tablet (.5 mg) of Lorazepam. An entry dated 12/27/22, with no time documented indicated LPN-A administered nine tablets (4.5 mg) of Lorazepam. A facility Medication/ Treatment Error Report dated 12/27/22, indicated medication as ordered: Lorazepam 0.5 milligrams (mg). Description of error: gave 4.5 mg. Staff member responsible was identified as LPN-A. The report indicated LPN-A verified the order but still heard it wrong and indicated staff to ask/inform prescriber that order needed to be written prior to dispensing. During interview on 1/5/23, at 3:10 p.m. the director of nursing (DON) stated the medication error occurred because LPN-A took a verbal order prior to the actual order being put into the system. The DON stated when she met with LPN-A she found out the hospice nurse had assessed R3 and gave a verbal order to administer Lorazepam because R3 was uncomfortable. The DON stated LPN-A repeated the dose back to the hospice nurse, then went to	F 760	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 DON reviewed all medication errors with no negative outcomes identified at this time. 3. Measures put into place/changes made to ensure the alleged deficient practice will not recur: " Education given to employee one on one with DON on 12/28/2022. " Adverse Consequences and Medication Error policy reviewed and updated. " Medication/Treatment Error Report has been updated to include clear instructions on steps to be taken in the event of a significant medication error occurs. " A committee has been developed to review medication errors monthly " Education was provided to all licensed nursing staff on 1/18/23 " Education will be provided to all licensed nurses on February 15, 2023 by facility consulting pharmacist. " Education provided to employee who was involved in the deficient practice. Education included medication administration documentation orders training, medication safety first alert regarding medication administration and orders, medication management and medication administration EduCare courses completed, medication administration guideline policy, video on near fatal medication errors, and also	

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 12 the registered nurse (RN) to clarify. The DON stated LPN-A was supposed to give Lorazepam 0.5 mg but gave 4.5 mg. The DON further stated she was still in the process of completing her investigation into the medication error but told LPN-A he needed to get written orders prior to administering medications. The DON stated she had not yet come up with a plan to proceed. On 1/5/23, at 4:22 p.m. RN-A stated she had completed the medication error form. RN-A stated the hospice nurse notified the physician who had responded "I am not going to say it's okay because that's not what I ordered." RN-A said they were told to hold the next to doses and monitor R3 for side effects like "sleepiness, breathing, stuff like that." RN-A stated she remembered the error because it was so significant but did not remember specific details because it had been awhile. RN-A stated she felt part of the problem was that LPN-A was a new nurse so he probably wouldn't have noticed the 4.5 mg was a high dose. During interview on 1/6/23, at 11:10 a.m. the hospice nurse practitioner (NP) stated she had been made aware of the error and had instructed staff to hold scheduled doses of Lorazepam until 8:00 p.m. and monitor R3. The NP stated "I would say it was a fairly significant medication error" and said she normally did not prescribe more than 2 mg. During interview on 1/6/23, at 12:44 p.m. the consulting pharmacists (CP) stated the potential side effects of the medication error included central nervous system depression, lethargy, and could increase the risk for falling. The CP stated the nurse should have clarified the order as it was	F 760	Lorazepam dosage and administration education on 1/10/2023. " Education provided to all nurses, universal workers, and TMAs regarding a video on near fatal medication errors and on updated Medication Administration Guidelines policy on 1/26/2023. " The DON will report to the quality assurance committee quarterly. 4. How the facility will monitor its corrective actions to ensure the alleged deficient practice will not recur: " Facility DON or designee will review all Medication error reports upon receipt to ensure error has been properly identified and addressed per facility policy. " A committee has been developed to review medication errors monthly. " Provide ongoing education at staff meetings. 5. Date alleged deficiencies will be corrected: " February 1, 2023	

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 13 outside the usual parameters for Lorazepam. A facility policy Adverse Consequences and Medication Errors dated 8/15/21, indicated the DON evaluates medication usage in order to prevent and detect adverse consequences and related problems such as adverse drug reactions and side effects. In the event of a significant medication-related error, immediate action is taken as necessary to protect the resident's safety and welfare. Data and errors will be complied and presented to the quality assurance and performance improvement committee on a monthly or quarterly basis.	F 760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 20, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: WLTB11

Dear Administrator:

The above facility was surveyed on January 5, 2023 through January 6, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 1/5/23 - 1/6/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH).our 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/26/23

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H55507189C (MN86688), with an order cited. The following complaints were found to be UNSUBSTANTIATED: H55507238C (MN89774), with related orders cited. 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		

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or	21545		2/1/23

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 3 toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 3 residents (R3) reviewed remained free from a significant medication error when Lorazepam (class of drugs known as benzodiazepines which act on the brain and nerves) was administered to R3 eight times the prescribed dose. Findings include: R3's quarterly Minimum Data Set identified severe cognitive impairment and indicated dependence on staff to complete activities of daily living. R3's care plan dated 12/28/22, identified a risk for pain and directed staff to administer medications as prescribed.	21545	Corrected	

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 4 R3's physician Order Summary Report dated 12/27/22, indicated Lorazepam oral tablet 0.5 mg. Place and dissolve 0.5 mg buccaly (in or near the cheek area) every four hours as needed for anxiety/restlessness and Lorazepam oral tablet 0.5 mg. Place and dissolve 0.5 mg buccaly every four hours for anxiety/restlessness. R3's Individual Narcotic Record indicated name of drug and dose: Lorazepam 0.5 mg. The record indicated on 12/27/22, at 8:54 a.m. LPN-A administered 1 tablet (.5 mg) of Lorazepam. An entry dated 12/27/22, with no time documented indicated LPN-A administered nine tablets (4.5 mg) of Lorazepam. A facility Medication/ Treatment Error Report dated 12/27/22, indicated medication as ordered: Lorazepam 0.5 milligrams (mg). Description of error: gave 4.5 mg. Staff member responsible was identified as LPN-A. The report indicated LPN-A verified the order but still heard it wrong and indicated staff to ask/inform prescriber that order needed to be written prior to dispensing. During interview on 1/5/23, at 3:10 p.m. the director of nursing (DON) stated the medication error occurred because LPN-A took a verbal order prior to the actual order being put into the system. The DON stated when she met with LPN-A she found out the hospice nurse had assessed R3 and gave a verbal order to administer Lorazepam because R3 was uncomfortable. The DON stated LPN-A repeated the dose back to the hospice nurse, then went to the registered nurse (RN) to clarify. The DON stated LPN-A was supposed to give Lorazepam 0.5 mg but gave 4.5 mg. The DON further stated she was still in the process of completing her investigation into the medication error but told	21545		

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 5 LPN-A he needed to get written orders prior to administering medications. The DON stated she had not yet come up with a plan to proceed. On 1/5/23, at 4:22 p.m. RN-A stated she had completed the medication error form. RN-A stated the hospice nurse notified the physician who had responded "I am not going to say it's okay because that's not what I ordered." RN-A said they were told to hold the next to doses and monitor R3 for side effects like "sleepiness, breathing, stuff like that." RN-A stated she remembered the error because it was so significant but did not remember specific details because it had been awhile. RN-A stated she felt part of the problem was that LPN-A was a new nurse so he probably wouldn't have noticed the 4.5 mg was a high dose. During interview on 1/6/23, at 11:10 a.m. the hospice nurse practitioner (NP) stated she had been made aware of the error and had instructed staff to hold scheduled doses of Lorazepam until 8:00 p.m. and monitor R3. The NP stated "I would say it was a fairly significant medication error" and said she normally did not prescribe more than 2 mg. During interview on 1/6/23, at 12:44 p.m. the consulting pharmacists (CP) stated the potential side effects of the medication error included central nervous system depression, lethargy, and could increase the risk for falling. The CP stated the nurse should have clarified the order as it was outside the usual parameters for Lorazepam. A facility policy Adverse Consequences and Medication Errors dated 8/15/21, indicated the DON evaluates medication usage in order to prevent and detect adverse consequences and	21545		

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 6 related problems such as adverse drug reactions and side effects. In the event of a significant medication-related error, immediate action is taken as necessary to protect the resident's safety and welfare. Data and errors will be complied and presented to the quality assurance and performance improvement committee on a monthly or quarterly basis. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medication were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 1 residents (R1) were treated with dignity and respect when a facility staff member aggressively took a cup from a residents hand, causing unintentional, minor	21805	Corrected	2/1/23

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 7 injury and made a verbal statement to R1 causing R1 to feel bad about herself. Findings include: R1's annual Minimum Data Set dated 12/2/22, identified intact cognition. R1's care plan dated 12/15/22, identified a self care deficit related to diagnosis of hypertensive encephalopathy and a history of transient ischemic attacks. A report to the state agency (SA) dated 12/29/22, indicated an incident occurred during a conversation between a facility staff member and R1, on 12/29/22, at 5:00 p.m. regarding R1's blood pressure. R1 stated trained medication aide (TMA)-A was upset and frustrated the other day. R1 stated TMA-A was yelling at her about all of her medication changes. R1 stated TMA-A handed her medications during the interaction and R1 said she would not take the medications until her blood pressure was checked. R1 said TMA-A was "set off" and grabbed the pill cup out of her hand. The report indicated R1 showed the staff member her hand. The staff member noted a couple of scratches to R1's left pinky finger. A facility investigation report dated 1/5/23, indicated the director of nursing (DON) met with R1 regarding the concern. R1 stated she had gone to see her physician earlier in the week and he had changed her medications again. R1 said she woke up on Wednesday and had breakfast in her room as usual and sometime after breakfast she felt dizzy and had a pain up her neck. R1 stated she did not report it as she thought it would pass. R1 said TMA-A came to her room around 11:00 a.m. with a plastic medication cup. R1 told TMA-A she felt dizzy and asked if she should have her blood pressure checked before taking her pills. R1 said she thought that had upset TMA-A who	21805		

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 8 asked her to take the pills first to which R1 replied "No, I don't want to take them without knowing my blood pressure." R1 stated TMA-A grabbed the cup out of her hand and said she felt a scratch on her finger at the time but did not think much of it until later. The report indicated R1 had two bruises on her fingers and a scratch. The report also indicated R1 stated as TMA-A was leaving her room she stopped in the doorway and said, "If you saw a real doctor you would have a pill that worked without all these med changes every day." During interview on 1/5/23, at 2:20 p.m. TMA-A stated, "I think this lady, I don't think she likes me." TMA-A stated she was concerned as R1 was her resident and said "the scratch, the bruising, I would never do anything like that." TMA-A stated she had long nails and indicated that may have caused the scratch unintentionally. TMA-A stated she brought the medications to R1 and she did not want to take them. TMA-A said "we were both frustrated." TMA-A said she took the cup from R1 and had another staff give the medications. TMA-A stated she did not remember saying anything about the physician except they had changed the medications again. During interview on 1/5/23, at 4:51 p.m. R1 stated she had trouble with her blood pressure and had gone to her physician quite a bit. R1 stated the day before the incident she had been to the clinic and the physician changed her medication and the time it was given. R1 stated TMA-A brought her two pills and she asked to have her blood pressure taken because she had been dizzy. R1 said she told TMA-A she was not going to take the pills without checking her blood pressure because she was afraid her blood pressure would "bottom out." R1 stated TMA-A grabbed the cup,	21805		

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 9 "she ripped it out of my hand" and said she got a cut and some bruising. R1 said she wasn't going to say anything and said, "I've heard her holler before." R1 stated after TMA-A ripped the cup out of her hand she stopped in the doorway and said, "you could go to a real doctor and maybe something could get resolved" and said she had never seen anyone with medication changes so many times. R1 stated she could see TMA-A was mad and said "she had an angry look on her face." R1 stated it made her feel terrible. R1 further stated, "I do feel like I was abused by her and I am afraid of her. She will probably come and say something to me like it's my fault." On 1/6/23, at 11:54 a.m. the administrator, DON and Social worker (SW) were interviewed. The DON stated a staff member had reported to her the conversation between R1 and TMA-A. The DON said initially R1 could not recall what day it had occurred but remembered TMA-A had been upset and talking with a raised voice. The DON said she went to R1's room and met with her and R1 shared the story with her. The DON stated R1 had a pinpoint mark on her finger and said it looked like a blood blister. The DON said the underside of R1's ring finger had faint blue bruising and some faint discoloration on the middle finger. The DON stated "we feel there was a misunderstanding between [R1] and [TMA-A]. R1 "thought [TMA-A] was upset with her." The DON said "in reality [TMA-A] was worried and concerned about [R1]." The DON stated she did not feel TMA-A's behavior was appropriate and had written up an action plan and planned to review it with TMA-A. The DON further stated TMA-A had not received any education but they planned to meet with her to present the corrective action plan and planned to have the staff development coordinator present education.	21805		

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 01/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 10 At the time of survey, TMA-A had not received any education related to resident dignity and respect, resident rights or abuse training to ensure immediate correction. A facility policy Reporting Mistreatment of Vulnerable Adults dated 7/11/22, indicated all residents have the right to be free form abuse, neglect, misappropriation of property and exploitation. The policy indicated the facility will follow all state and federal regulations for abuse prevention and protection of vulnerable adults. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		