

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/23/2025
NAME OF PROVIDER OR SUPPLIER  Country Manor Health & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  520 First Street Northeast Sartell, MN 56377	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49035</b></p> <p>Based on observation, interview and document review, the facility failed to monitor 1 of 2 residents (R97) reviewed for wound care.</p> <p>Findings include:</p> <p>R97's quarterly Minimum Data Set (MDS) dated [DATE], included R97 had moderate cognitive impairment. R97 had a diagnosis of dementia.</p> <p>R97's encounter summary dated 12/20/24 from Central MN Foot &amp; Ankle included Staff at Country Manor are to clean the right great toe with warm water and gentle soap; gently pat dry, then apply a thin layer of triple antibiotic ointments followed by a band-aid until healed.</p> <p>R97's interdisciplinary notes dated 12/20/24, included right great toe bandage changed. Mild bleeding noted. Cleaned and applied abx ointments. Interdisciplinary notes failed to include additional entries describing skin impairment or treatment.</p> <p>During interview on 1/22/25 at 4:56 p.m., registered nurse (RN)-A stated she was unsure if R97 had a skin impairment to her right great toe. RN-A confirmed R97's electronic medical record (EMR) lacked monitoring and documentation on a skin impairment to the right great toe. RN-A confirmed there was a daily wound care order for R97 which was being documented on daily as being completed.</p> <p>During interview on 1/23/25 at 9:34 a.m., director of nursing (DON) stated there should be monitoring set up when a resident has a skin impairment. The DON stated wound documentation including appearance, size and drainage should have been completed at a minimum weekly. The DON confirmed there was an order for daily wound care to R97's right great toe. The DON confirmed R97's EMR failed to include any documentation of a skin impairment to R97's right great toe since 12/20/24. The DON stated it was important to have monitoring and documentation to watch for progress or changes to the skin impairment.</p> <p>Undated facility document titled Skin Condition Review included all nursing staff are responsible for monitoring the effectiveness of implemented interventions and in making necessary changes.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49654</p> <p>Based on interview and document review, the facility failed to identify an outbreak of gastrointestinal (GI) illness, implement corrective action to reduce the spread of illness and infections in the facility and report the outbreak to the State Agency (SA). This had the potential to affect all 124 residents in the facility and facility staff.</p> <p>Findings include:</p> <p>The facility's infection/tracking and monitoring spreadsheet tracked unit name, resident name, room number, admitted , existing infection from previous month(s), infection type, body system of infection, surveillance definition met, symptom(s), onset date, and date symptoms resolved. Review of the spreadsheet from December 1, 2024, through January 21, 2025, revealed the following:</p> <p>Nine residents in the month of December were identified with GI concerns:</p> <p>-8 residents were identified to reside on the Pioneer Village unit with an infection type of gastroenteritis. The date of first onset was 12/3/24 and the date of last symptoms resolved was 12/17/24. Symptoms included emesis, loose stools, and nausea.</p> <p>-1 resident was identified to reside on the Rapid Recovery 2 unit with an infection type of gastroenteritis. The date of first onset was 12/12/24 and the date of last symptoms resolved was 12/17/24. Symptoms included emesis, nausea.</p> <p>Four residents in the month of January were identified with GI concerns:</p> <p>-2 residents were identified to reside on the Garden Cottage unit with an infection type of gastroenteritis. The date of first onset was 1/12/25 and the date of last symptoms resolved was 1/19/25. Symptoms included loose stools and nausea.</p> <p>-2 residents were identified to reside on the Rapid Response 1 unit with an infection type of gastroenteritis. The date of first onset was 1/17/25 and the date of last symptoms resolved was blank. Symptoms included loose stools and vomiting.</p> <p>The spreadsheet lacked identification of precautions or interventions implemented in response to the identified infections.</p> <p>A document titled Infection Control dated December 2024, which included analysis of facility infections, identified nine GI nosocomial (facility acquired) infections for the month of December. The section for conclusion/actions was blank. An Infection Control Analysis document was not provided for January 2025.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's Employee Illness Log dated December 2024 identified symptoms tracked to include vomiting only, diarrhea only, Cold or Respiratory infection, Influenza/COVID symptoms, positive for influenza, positive for COVID-19, C-Diff (Clostridiodes difficile, a bacterial infection that causes diarrhea and inflammation of the colon), pink eye, GI, skin issues, strep throat, mono (Mononucleosis-a contagious viral illness), other medical, ill child/family, and personal. The number of infections were tracked by unit or department which included Pioneer Village, Garden Cottage, Rapid Recovery 1, Rapid Recovery 2, Activities, Therapy, Dietary, Social Service, Housekeeping &amp; Laundry, Maintenance, and On-call/Support Staff. Review of the log revealed the following:</p> <p>Twenty-eight staff were identified with GI concerns in the month of December:</p> <p>-1 staff member from Pioneer Village and 1 staff member from the Activity department were identified with diarrhea only.</p> <p>-11 staff from Pioneer Village, 7 staff from Garden Cottage, 6 staff from Rapid Recovery 1, 6 staff from Rapid Recovery 2, 1 staff from Housekeeping &amp; Laundry and 2 on-call/support staff were identified with GI concerns.</p> <p>The Employee Illness Log for the month of January was requested but not provided.</p> <p>The log lacked identification of dates of illness, resolution of employee symptoms, return to work criteria met or any precautions or interventions implemented to reduce the spread of infections in the facility.</p> <p>Review of the Weekly Quality Council Minutes dated December 31, 2024, January 7, 2025, and January 14, 2025, indicated infection trends/patterns were reviewed and discussed and revealed the following:</p> <p>-12/31/24: identified eight residents with GI symptoms with 8 residing on one wing.</p> <p>-1/7/25: indicated GI cases stabilized.</p> <p>-1/14/25: nosocomial infections/rates-increase in GI infection in December.</p> <p>The minutes did not address employee illnesses or identify actions taken by the facility to address the outbreak or concerns.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 1/23/24 at 12:00 p.m., the infection preventionist (IP) stated she obtained information for infection control surveillance from the nursing staff, case managers, and resident chart documentation to identify potential infections and look for patterns. IP reviewed the facility infection control surveillance logs and verified the resident and employee infections as listed above. She stated infection prevention information was reviewed daily at the interdisciplinary team meeting, weekly on Tuesdays during Quality council meetings and monthly during Quality Assurance and Performance Improvement meetings. She denied any recent outbreaks in the facility, however, confirmed there had been a pattern of eight residents on the Pioneer Village unit with GI symptoms beginning in December. She logged the information on her spreadsheet, made sure the residents were on droplet and contact precautions and indicated the precautions could be discontinued after the resident was asymptomatic for 72 hours. She had been concerned about the potential the GI symptoms were norovirus (a group of viruses that can cause gastroenteritis, an inflammation of the stomach and intestines) and spoke with the facility nurse practitioner regarding testing. However, the nurse practitioner (NP) had told her she didn't think the local hospital performed the test. She did not contact the hospital herself to confirm testing availability. She denied any outbreak of food-borne illness in the facility but stated food-borne illness went hand in hand with a GI outbreak. If an outbreak occurred, she would look to see if there was something in common the residents ate and talk with the dietary manager regarding dietary employee GI illness. However, she had not spoken to any of the dietary staff in December regarding GI illness and was only aware of three staff with respiratory illness. After this discussion she stated she would consider eight residents on one unit an outbreak. She denied any action was taken to prevent the spread of GI illness to other units of the facility or to employees, outside of placing the symptomatic residents under droplet and contact precautions. No testing of the resident for the infectious organism occurred, no education to staff was provided and the outbreak was not reported the state agency.</p> <p>During interview on 1/23/25 at 1:38 p.m., nurse practitioner (NP) stated she was aware of multiple residents and staff with reported GI symptoms in the month of December. NP stated she considered 8 residents residing on the same unit, with the same reported symptoms, as an outbreak. She was unsure of how many staff were affected with GI symptoms but that would be taken into consideration as well. Residents were placed in contact/droplet precaution and NP denied further action regarding the GI illness in the facility.</p> <p>During interview on 1/23/25 at 12:35 p.m., the director of nursing was unaware of the pattern of GI illness in the facility but stated eight residents on one unit would and could be looked at as an outbreak. Her expectations were for the IP to address the outbreak per the facility policy to include placing the residents in the appropriate precautions, the use of isolation bins, signs alerting staff and visitors, hand hygiene, the affected residents eating in their room and reporting the outbreak to the SA, if appropriate. She would have expected the IP follow up with the laboratory to have testing due to the potential type of infection. If the outbreak was contagious, it would be important to identify what it is to help stop the spread and determine a treatment. As well as protect the health of the other residents and make sure we are following current guidelines.</p> <p>(continued on next page)</p>		

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F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	The Management of Gastrointestinal Illness/Outbreak policy last reviewed 6/24, directed it was policy of this facility that once loose, watery stools have been evaluated, prevention and outbreak management measures must be followed. The policy defined Gastroenteritis as inflammation of the stomach and small and large intestines. Viral gastroenteritis (norovirus) is an infection caused by a variety of viruses that result in vomiting or diarrhea. It is often called the 'stomach flu'. The policy further defined an outbreak as three or more cases of diarrhea on one specific unit, and directed staff to discontinue group activities where sick and well residents would be together, group activities should be kept to a minimum or postponed until outbreak is over; minimize the flow of staff between sick and well residents; staff should be assigned to work with either well or sick residents, but not care for both groups; a sign will be posted at the entrances of the facility explaining to visitors/friends that the facility's residents are experiencing GI symptoms; the infection preventionist/designee will inform the medical director and request orders for cultures on 2-3 residents who are experiencing symptoms; the infection preventionist/designee will call the Department of Health and inform them of the suspected outbreak and do updates as necessary; the clinical managers/supervisors, under the direction of the director of nursing and the infection preventionist/designee, will assist with in-servicing the staff on the criteria, guidelines, and recommendations; the infection preventionist/designee will report resolution to appropriate public health agencies and gather collected data for final narrative report.		